

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

## State of Maryland / Department of Health and Mental Hygiene

ITEMS: #10E PER F.H. G767 1-29-99 WR.

## Certificate of Death

Reg. No. 98 41001

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>RETTA H. LANE</b>				2. Date of Death Month Day Year <b>December 12, 1998</b>		3. Time of Death <b>16:30 p</b>		
	4a. Facility Name (If not institution, give street and number) <b>The Johns Hopkins Hospital Baltimore</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>BALTIMORE</b>		
Funeral Director	5. Social Security Number <b>222-12-4629</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>81</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>FEB 17, 1917</b>		
	9. Birthplace (State or Foreign Country) <b>DELAWARE</b>		10a. State <b>DE</b>		10b. County <b>KENT</b>		10c. City, Town or Location <b>MILFORD</b>		
Usual Residence of Decedent		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number <b>6442 CHATEAU DRIVE</b>		10f. Zip Code <b>19963</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>3</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>REGISTERED NURSE</b>		16b. Kind of Business/Industry <b>PHYSICIANS OFFICE</b>		17. Father's Name (First, Middle, Last) <b>JOHN HENDRICKS</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>GRACE BEER</b>	
19a. Informant's Name/Relationship (Type, Print) <b>CAROLYN LANK</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4142 ALTA VISTA AVE, SANTA ROSA, CA 95404</b>		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>ODD FELLOWS CEMETERY</b>		20c. Location - City or Town, State <b>12-16 MILFORD, DE</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>BERRY-SHORT FUNERAL HOME 119 NW FRONT ST., MILFORD DE 19963</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. MULTIPLE ORGAN FAILURE</b> Due to (or as a consequence of): <b>b. CORONARY ARTERY AND CORONARY VALVULAR DISEASE</b> Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.		Approximate Interval Between Onset and Death <b>3 DAYS</b>			
23a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <b>12/12/98</b>		28b. Time of Injury <b>M</b>	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>RES-000</b>		29d. Date signed (Month, Day, Year) <b>12/12/98</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DECLAN HEGARTY MD JOHNS HOPKINS HOSPITAL, BALTIMORE, MD</b>		31. Date filed (Month, Day, Year) <b>JAN 07 1999</b>		32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41002

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transfer

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Joshua Shayne PHELPS</b>		2. Date of Death Month <b>December</b> Day <b>30</b> Year <b>1998</b>		3. Time of Death <b>4:08 P.M.</b>	
4a. Facility Name (If not institution, give street and number) <b>Frederick Memorial Hospital</b>		4b. City, Town, or Location of Death <b>Frederick</b>		4c. County of Death <b>Frederick</b>	
5. Social Security Number <b>216-53-5518</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) Yrs. <b>2</b> Months <b>18</b> Days <b>18</b>	
8. Date of Birth (Month, Day, Year) <b>October 12, 1998</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>			
Usual Residence of Decedent					
10a. State <b>Maryland</b>		10b. County <b>Washington</b>		10c. City, Town or Location <b>Hagerstown</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>1306 Outer Drive</b>		10f. Zip Code <b>21742</b>	
10g. Citizen of What Country? <b>U.S.A.</b>		11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>0</b> College (1-4 or 5+)	
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Never Worked</b>		16b. Kind of Business/Industry <b>NONE</b>		17. Father's Name (First, Middle, Last) <b>Jon Dwight PHELPS, JR.</b>	
18. Mother's Name (First, Middle, Maiden Surname) <b>Stephanie LILLARD</b>		19a. Informant's Name/Relationship (Type, Print) <b>Mr. Jon Dwight Phelps, Jr., Father</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1306 Outer Drive, Hagerstown, Maryland 21742</b>	
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mount Olivet Cemetery, Jan. 4, 1999</b>		20c. Location - City or Town, State <b>Frederick, Maryland</b>	
21. Signature of Funeral Service Licensee <b>Richard E. [Signature]</b> MO0255		22. Name and Address of Facility <b>Keeney and Basford P.A. Funeral Home 106 East Church St., Frederick, MD 21701</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <b>a. SUDDEN INFANT DEATH, NOT OTHERWISE SPECIFIED</b> Due to (or as a consequence of):  <b>b.</b> Due to (or as a consequence of):  <b>c.</b> Due to (or as a consequence of):  <b>d.</b>	
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined	
28a. Date of Injury (Month, Day, Year) <b>12-30-98</b>		28b. Time of Injury <b>UNKNOWN M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred <b>UNKNOWN</b>		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>HOME</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>535 LOGAN ST. FREDERICK, MD.</b>	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>J. Pestaner, MD.</b>		29c. License number <b>O.C.M.E.</b>	
29d. Data signed (Month, Day, Year) <b>December 31, 1998</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201</b>		31. Data filed (Month, Day, Year) <b>JAN 07 1999</b>	
32. Registrar's Signature <b>[Signature]</b>		33. State Registrar <b>[Signature]</b>			

*[Handwritten signature]*

END OF MAIL

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State of Maryland / Department of Health and Mental Hygiene 98 41003

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Selvia Flossie Phelps				2. Date of Death Month Day Year Dec 15 1998		3. Time of Death 8:20pm		
	4a. Facility Name (If not institution, give street and number) 1701 Woodstock Road				4b. City, Town, or Location of Death Woodstock		4c. County of Death Howard		
Funeral Director	5. Social Security Number 213-34-2233	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 96	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Mar 31 1902		9. Birthplace (State or Foreign Country) Ohio	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State Md	10b. County Howard		10c. City, Town or Location Woodstock			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 1701 Woodstock Road			10f. Zip Code 21163		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 Collega (1-4 or 5+) 11			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) homemaker			16b. Kind of Business/Industry domestic		
	17. Father's Name (First, Middle, Last) Bert Farley				18. Mother's Name (First, Middle, Maiden Surname) Louella Day Napple				
	19a. Informant's Name/Relationship (Type, Print) Margaret Sybert (granddaughter)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 511 Ricketts Mill Rd., Elkton, MD 21921				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Morris Cemetery		20c. Date 12-20-98		20d. Location - City or Town, State Moatsville, WV		
	21. Signature of Funeral Service Licensee ► Paige Haight Herbert				22. Name and Address of Facility Haight Funeral Home & Chapel P.O. Box 195 Sykesville, MD 21784				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Metastatic Breast Cancer Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 4 yrs
	Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. Atherosclerosis								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)						
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				
	28f. Location (Street and Number or Rural Route Number, City or Town, State)								
	29a. Certifier (Check only one) 3 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier HACK				29c. License number D31172		29d. Date signed (Month, Day, Year) Dec 17 1998			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) H.A. OKEN MD 3460 ELLICOTT STEN DR 103 EC MD 21043									
State Registrar	31. Date filed (Month, Day, Year) DEC 18 1998		32. Registrar's Signature B. Sparks						

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41004

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Elizabeth I. Thompson				2. Date of Death Month Day Year December 24, 1998				3. Time of Death 1530		
	4a. Facility Name (If not institution, give street and number) Sunrise Care and Rehabilitation				4b. City, Town, or Location of Death Elkton				4c. County of Death Cecil		
Funeral Director	5. Social Security Number 171-10-2849		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 81 Yrs.		8. Date of Birth (Month, Day, Year) June 26, 1917		9. Birthplace (State or Foreign Country) Pennsylvania		
	Usual Residence of Decedent				10a. State Pennsylvania				10b. County Chester		
To Be Completed by Funeral Director	10c. City, Town or Location Oxford				10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No						
	10e. Street and Number Ox Haven Apartments				10f. Zip Code 19363				10g. Citizen of What Country? United States		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Food Handler				16b. Kind of Business/Industry Hospital		
	17. Father's Name (First, Middle, Last) Pierce Ingram				18. Mother's Name (First, Middle, Maiden Surname) Mary Hale						
	19a. Informant's Name/Relationship (Type, Print) Ethel Kay Yates/ Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 103 North Deer Run Drive, Lincoln University, 19352 Pennsylvania						
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) R.A. Ferris and Company		Date December 28, 1998		20c. Location - City or Town, State West Chester, Pennsylvania				
	21. Signature of Funeral Service Licensee <i>Donna S. Hicks</i>				22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 West Stockton Street, Elkton, Maryland 21921						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. <i>Dementia</i> Due to (or as a consequence of): b. <i>Cerebrovascular Disease</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death <i>Yrs.</i> <i>Yrs.</i>										
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Atrial Fibrillation</i> <i>Hypothyroidism</i> <i>Hypertension</i>				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>S. S. Schender MD</i>				29c. License number D23322		29d. Date signed (Month, Day, Year) 12/28/98	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. S. Schender, 118 North St Suite 8B, Elkton MD 21921				31. Date filed (Month, Day, Year) DEC 28 1998				32. Registrar's Signature <i>S. S. Schender</i>			

Baltimore, Maryland 21215-0020

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41005

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Freddie L. Williams

2. Date of Death

December 23, 1998

3. Time of Death

3:11 PM

4a. Facility Name (If not institution, give street and number)

Harford Memorial Hospital

4b. City, Town, or Location of Death

Havre de Grace

4c. County of Death

Harford

Funeral  
Director

5. Social Security Number

291-40-3221

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

54 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

July 9, 1944

9. Birthplace (State or Foreign Country)

Ohio

Usual Residence of Decedent

10a. State

Maryland

10b. County

Cecil

10c. City, Town or Location

Conowingo

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

80 W. Red Hill Rd.

10f. Zip Code

21918

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: 1968-69

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Shop Steward

16b. Kind of Business/Industry

Carpentry

17. Father's Name (First, Middle, Last)

unknown

18. Mother's Name (First, Middle, Maiden Surname)

unknown

19a. Informant's Name/Relationship (Type, Print)

Idalyn O. Williams/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

80 West Red Hill Rd., Conowingo, MD 21918

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

State Line Baptist Cem.

Date

12-28-98

20c. Location - City or Town, State

Rising Sun, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

R. T. Foard Funeral Home, P. A.

111 S. Queen St., Rising Sun, MD 21911

23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. myocardial infarction

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Artherosclerotic Cardiovascular disease

Due to (or as a consequence of):

years

c. tobacco abuse

Due to (or as a consequence of):

years

d. Insulin dependent diabetes

years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

hyperlipidemia

hypertension

diabetic nephropathy

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Wendy Kloss, MD

29c. License number

D31295

29d. Date signed (Month, Day, Year)

12/24/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Wendy Kloss, MD 16 Aberdeen Plaza Aberdeen MD 21001

31. Date filed (Month, Day, Year)

DEC 28 1998

32. Registrar's Signature

Beverly G. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41006

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) <b>MARGARET GERTRUDE WILHELM</b>		2. Date of Death Month Day Year <b>DEC. 16, 1998</b>		3. Time of Death <b>7:25 PM</b>	
4a. Facility Name (If not institution, give street and number) <b>835 RAMPART WAY</b>		4b. City, Town, or Location of Death <b>UNION BRIDGE</b>		4c. County of Death <b>CARROLL</b>	
5. Social Security Number <b>213-09-5420</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>81</b> Yrs.	
8. Date of Birth (Month, Day, Year) <b>12/24/1916</b>		9. Birthplace (State or Foreign Country) <b>MARYLAND</b>			
Usual Residence of Decedent		10a. State <b>MD.</b>		10b. County <b>CARROLL</b>	
10c. City, Town or Location <b>UNION BRIDGE</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number <b>835 RAMPART WAY</b>		10f. Zip Code <b>21791</b>		10g. Citizen of What Country? <b>USA.</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+)		16. Kind of Business/Industry <b>HOUSEWIFE HOME MAKING</b>	
17. Father's Name (First, Middle, Last) <b>JAMES ABBOTT</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>GARAFIELA HARE</b>			
19a. Informant's Name/Relationship (Type, Print) <b>PATRICIA DERR - DAUGHTER</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>835 RAMPART WAY, UNION BRIDGE, MD, 21791</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>WESTMINSTER CEM.</b>		20c. Location - City or Town, State <b>12/19/98 WESTMINSTER, MD.</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157</b>			
23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE YEARS</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):		Approximate Interval Between Onset and Death			
Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>COPD</b>		23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>D14317</b>	
29d. Date signed (Month, Day, Year) <b>12/18/98</b>		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>WILLIAM R LINTHICUM, M.D ONE KINGS DR. P.O. BOX 452 TANEYTOWN MD 21787</b>			
31. Date filed (Month, Day, Year) <b>DEC 18 1998</b>		32. Registrar's Signature 			

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 41007

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>WILLIE BRYANT</b>				2. Date of Death Month: <b>Dec</b> Day: <b>30</b> Year: <b>98</b>		3. Time of Death <b>13:50</b>	
	4a. Facility Name (If not institution, give street and number) <b>Sinai</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>218-44-5121</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>53</b> Yrs.	If Under 1 Year Months: Days:	If Under 24 Hrs. Hours: Min.	8. Date of Birth (Month, Day, Year)		9. Birthplace (State or Foreign Country) <b>N. CAROLINA</b>
	Usual Residence of Decedent							
10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>2651 OSWEGO AVE.</b>				10f. Zip Code <b>21215</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) <b>2yr.</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>LAW CLERK</b>			16b. Kind of Business/Industry <b>LAW</b>	
17. Father's Name (First, Middle, Last) <b>WILLIE SWIFT</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>ODELL BRYANT</b>				
19a. Informant's Name/Relationship (Type, Print) <b>VALERIE BRYANT-WIFE</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2651 OSWEGO AVE. BALTO., MD. 21215</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>GARRISON FOREST</b>		20c. Location - City or Town, State <b>116/99 OWINGS MILLS, MD.</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>BABY'S MARCH FUNERAL HOME, PA. 21229</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>CARDIAC ARRHYTHMIA</b> Due to (or as a consequence of): b. <b>CARDIOMYOPATHY</b> Due to (or as a consequence of): c. <b>ASCVD</b> Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death <b>MINUTES</b> <b>YEARS</b> <b>YEARS</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CHRONIC RENAL FAILURE</b>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				
28f. Location (Street and Number or Rural Route Number, City or Town, State)				28e. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number <b>D16349</b>		29d. Date signed (Month, Day, Year) <b>1.6.99.</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>CEDRIC W. BRYAN MD 827 LINCOLN AVE BALTIMORE MD 21201</b>								
31. Date filed (Month, Day, Year) <b>JAN 8 1999</b>				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

VICTOR TIMOTHY GRAP

ITEMS: #23 PART 1, 27, 28A-F PER MEO

6767-1-13-99 WP  
Certificate of Death

Reg. No. 98 4 1008

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
Examiner

Funeral  
Director

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last) <b>Victor Timothy Grap</b>		2. Date of Death Month Day Year <b>DECEMBER 23, 1998</b>		3. Time of Death <b>2156 PM</b>	
4a. Facility Name (If not institution, give street and number) <b>2012 CHRISTIAN STREET</b>		4b. City, Town, or Location of Death <b>BALTIMORE CITY</b>		4c. County of Death <b>N/A</b>	
5. Social Security Number <b>219-68-1380</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>37</b> Yrs.	
8. Date of Birth (Month, Day, Year) <b>FEB 11, 1961</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>			
Usual Residence of Decedent					
10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>UNK.</b>		10f. Zip Code <b>UNK.</b>	
10g. Citizen of What Country? <b>USA</b>		11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1982/</b>	
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>	
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Never Worked</b>		16b. Kind of Business/Industry <b>N/A</b>		17. Father's Name (First, Middle, Last) <b>Elmer Thomas Grap, Jr.</b>	
18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Etta Johnson</b>		19a. Informant's Name/Relationship (Type, Print) <b>Mary E. Ringrose/mother</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>123 Thomas Road Glen Burnie, MD 21061</b>	
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory, Inc.</b>		20c. Location - City or Town, State <b>Baltimore, MD</b>	
21. Signature of Funeral Service Licensee <b>Dawn F. McDonald</b>		22. Name and Address of Facility <b>Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>HYPOTHERMIA</b> Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>AT SCENE</b>		27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined	
28a. Date of Injury (Month, Day Year) <b>12-23-98</b>		28b. Time of Injury <b>UNKNOWN</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred <b>EXPOSURE TO COLD</b>		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>VACANT BUILDING</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>2012 CHRISTIAN ST BALTIMORE, MD.</b>	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Stephen S. Radentz, MD</b>		29c. License number <b>OCME</b>	
29d. Date signed (Month, Day, Year) <b>DECEMBER 24, 1998</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201</b>		31. Date filed (Month, Day, Year) <b>JAN 8 1999</b>	
32. Registrar's Signature <b>[Signature]</b>					





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41009

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Julia Emma Thompson Gilkes				2. Date of Death Month Day Year December 29, 1998		3. Time of Death 3:55 P.M.	
	4a. Facility Name (If not institution, give street and number) Doctors Community Hospital				4b. City, Town, or Location of Death Lanham		4c. County of Death Prince George's	
Funeral Director	5. Social Security Number Not Available		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 93 Yrs.		8. Date of Birth (Month, Day, Year) August 2, 1905	
	9. Birthplace (State or Foreign Country) New York		10. Usual Residence of Decedent 10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Mitchellville	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 10450 Lottsford Road		10f. Zip Code 20721		10g. Citizen of What Country? United States of America	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Registered Nurse		16b. Kind of Business/Industry Health Care			
	17. Father's Name (First, Middle, Last) Percy Thompson				18. Mother's Name (First, Middle, Maiden Surname) Amy Ellis			
	19a. Informant's Name/Relationship (Type, Print) Edith T. Scott /Niece				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11150 Homewood Road, Ellicott City, Maryland 21042			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Beechwoods Cemetery		Date January 6, 1999		20c. Location - City or Town, State New Rochelle New York	
	21. Signature of Funeral Service Licensee Howard A. Conson				22. Name and Address of Facility McCallihan Funeral Home 30 Winthrop Avenue, New Rochelle, New York			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Sepsis Due to (or as a consequence of): b. Acute Renal Failure Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	Approximate Interval Between Onset and Death Weeks Weeks							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Atherosclerosis Multiple Infected Decubitus Ulcer Hypotension						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
		28d. Describe how injury occurred		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Rakesh Arora		29c. License number D 20108		29d. Date signed (Month, Day, Year) December 30, 1998		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Rakesh Arora, M.D. 14300 Gallant Fox Lane, Suite 222, Bowie, Maryland								
31. Date filed (Month, Day, Year) JAN 8 1999		32. Registrar's Signature B. Sparks						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



*Handwritten signature or text, possibly "J. M. Smith".*

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 41010

Item: 1 per M.D G-767 1/8/99 reb

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last) TYREE DEON GREEN *green* 2. Date of Death Month Day Year DECEMBER 26, 1998 3. Time of Death 01:54 AM

4a. Facility Name (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL 4b. City, Town, or Location of Death BALTIMORE CITY 4c. County of Death NA

Funeral  
Director

5. Social Security Number NA 6. Sex ☒ M ☐ F 7. Age (In yrs. last birthday) Yrs. Months Days 1 8. Date of Birth (Month, Day, Year) 12-26-98 9. Birthplace (State or Foreign Country) MD

Usual Residence of Decedent

10a. State MD 10b. County NA 10c. City, Town or Location Baltimore 10d. Inside City Limits ☒ Yes ☐ No

10e. Street and Number 2443 E. Hoffman Street 10f. Zip Code 21213 10g. Citizen of What Country? USA

11. Marital Status ☒ Never Married ☐ Married ☐ Widowed ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? ☐ Yes ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ Yes ☒ No Specify: 14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collegia (1-4 or 5+) Infant NA 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Child 16b. Kind of Business/Industry Child

17. Father's Name (First, Middle, Last) Unknown 18. Mother's Name (First, Middle, Maiden Surname) Regina A. Green

19a. Informant's Name/Relationship (Type, Print) Regina A. Green 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21213 2443 E. Hoffman Street Baltimore, MD

20a. Method of Disposition ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Voshell Mem. Gardens 01-08-99 Dundalk, MD 20c. Location - City or Town, State

21. Signature of Funeral Service Licensee *Alvin M. Davis* 22. Name and Address of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue

23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) a. myocardial dysfunction 22 hours Due to (or as a consequence of): b. hypoxic - ischemic insult unknown Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

hypoxic - ischemic hepatic insult 23b. Did tobacco use contribute to the cause of death? ☐ Yes ☒ No ☐ Probably ☐ Unknown probable acute tubular necrosis 24a. Was an autopsy performed? ☒ Yes ☐ No 24b. Were autopsy findings available prior to completion of cause of death? ☐ Yes ☒ No hypoxic - ischemic encephalopathy

25. Was case referred to medical examiner? ☐ Yes ☒ No 26. Place of Death (Check only one) Hospital: ☒ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death 1 ☒ Natural 5 ☐ Pending investigation 2 ☐ Accident 6 ☐ Could not be determined 3 ☐ Suicide 4 ☐ Homicide 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? ☐ Yes ☒ No 28d. Describe how injury occurred 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier *Karen Lantz MD* 29c. License number RES-000 29d. Date signed (Month, Day, Year) December 26, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KAREN LANTZ MD 600 North Wolfe Street Baltimore Maryland 21287

31. Date filed (Month, Day, Year) JAN 8 1999 32. Registrar's Signature *Bernice B. Sparks*

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



98-7498-033  
98-294

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

CHARLES HUNDLEY ITEM: #23 PART 1, PER MEO G768 2-3-99-11-99 WR  
ITEMS: #23 PART 1, 27, 28A-F PER MEO G768 2-3-99-11-99 WR

Certificate of Death

Reg. No. 98 41011

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Charles Alan Hundley					2. Date of Death Month Day Year DECEMBER 20, 1998		3. Time of Death 5:10P.M.							
	4a. Facility Name (If not institution, give street and number) 6000 WOODYARD ROAD					4b. City, Town, or Location of Death CLINTON		4c. County of Death PRINCE GEORGES							
Funeral Director	5. Social Security Number 229-17-3187		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 34 Yrs.		8. Date of Birth (Month, Day, Year) May 20, 1964		9. Birthplace (State or Foreign Country) Washington, DC						
	Usual Residence of Decedent														
10a. State Virginia		10b. County Fairfax County		10c. City, Town or Location Annandale				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
10e. Street and Number 4616 Willow Run Drive					10f. Zip Code 22003		10g. Citizen of What Country? United States of America								
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White							
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Carpenter			16b. Kind of Business/Industry Building/Construction							
17. Father's Name (First, Middle, Last) Alan Taylor Hundley					18. Mother's Name (First, Middle, Maiden Surname) Josephine Ann Reed										
19a. Informant's Name/Relationship (Type, Print) Josephine R. Brown /Mother					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Route 2, Montross, Virginia 22520										
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory			Date December 25, 1998		20c. Location - City or Town, State Alexandria, Virginia							
21. Signature of Funeral Service Licensee Howard A. Hansen					22. Name and Address of Facility Welch Funeral Home Montross, Virginia										
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. NARCOTIC & COCAINE INTOXICATION COMPLICATED BY CARBON MONOXIDE INTOXICATION Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) SCENE												
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input checked="" type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year) Found: 12-20-98		28b. Time of Injury Found: 4:56 P M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred USED DRUGS & INHALED EXHAUSE FUMES FROM CAR 28f. Location (Street and Number or Rural Route Number, City or Town, State) WOODYARD, 6000 BLOCK CLINTON, MARYLAND						
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										29b. Signature and title of certifier Howard A. Hansen		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) DECEMBER 21, 1998	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) H. S. RYSLERSON P. K. KOSOW 111 Penn Street, Baltimore, Maryland 21201															
31. Date filed (Month, Day, Year) JAN 8 1999			32. Registrar's Signature B. A. Spahr												

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



98 41012

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Ethel Harvey</i>				2. DATE OF DEATH MONTH <i>12</i> DAY <i>31</i> YEAR <i>98</i>		3. TIME OF DEATH <i>6:30 A.M.</i>	
4. SOCIAL SECURITY NUMBER <i>217-26-4952</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (If yrs. last birthday) <i>80</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>3/17/1918</i>	
8. BIRTHPLACE (State or Foreign Country) <i>VIRGINIA</i>				9. COUNTY OF DEATH <i>n/a</i>			
9a. FAMILY NAME (If not institution, give street and number) <i>JUTICE CARE Homewood</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore, Md</i>			
RESIDENCE OF DECEDENT							
10a. STATE <i>MD.</i>		10b. COUNTY <i>N/A</i>		10c. CITY, TOWN OR LOCATION <i>BALTIMORE</i>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <i>2503 VIOLET AVENUE</i>				10f. ZIP CODE <i>21215</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U.S. OF A.</i>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>BLACK</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>N/A</i> College (13-16 or 5+) <i>N/A</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>NURSES AID</i>		16b. KIND OF BUSINESS/INDUSTRY <i>HOSPITAL</i>			
17. FATHER'S NAME (First, Middle, Last) <i>THOMAS GARDNER</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>INDIA TALIFERRO GARDNER</i>			
19a. INFORMANT'S NAME (Type/Print) <i>MOSES GARDNER (BROTHER)</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1803 PENROSE AVENUE BALTO., MD. 21223</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, funeral home, or other place) <i>CEDAR HILL CEM. 1/5/99</i>		20c. LOCATION — City or Town, State <i>BALTO., MD. A.A. Co.</i>		20d. DATE <i>1/5/99</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Lewis T. Gwynn</i>				22. NAME AND ADDRESS OF FACILITY <i>LEWIS T. GWYNN FUNERAL HOME 21215-639 4517 PARK HEIGHTS AVE BALTO., MD.</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <i>Immobility syndrome</i> DUE TO (OR AS A CONSEQUENCE OF):				Approximate Interval Between Onset and Death <i>&gt; 7 months</i>	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. <i>Adult marasmus</i> DUE TO (OR AS A CONSEQUENCE OF):				<i>&gt; 1 year</i>	
		c. <i>Dementia</i> DUE TO (OR AS A CONSEQUENCE OF):				<i>&gt; 2 years</i>	
		d.					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Chronic renal failure Cerebrovascular disease Type II diabetes mellitus, Right lung cancer</i>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>J. Boston MD 201</i>				29c. LICENSE NUMBER <i>028462</i>		29d. DATE SIGNED (Month, Day, Year) <i>December 31, 1998</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH, (ITEM 27) (Type, Print) <i>J. Boston 2018 University Parkway Balto, MD 21218</i>							
31. DATE FILED (Month, Day, Year) <i>JAN 8 1999</i>		32. REGISTRAR'S SIGNATURE <i>B. Sparks</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41013

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

VESTINE JOHNSON

2. Date of Death

December 24, 1998

3. Time of Death

2:31 pm

4e. Facility Name (If not institution, give street and number)

Sinai Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Funeral  
Director

5. Social Security Number

217-54-4633

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

49

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

09 11 49

9. Birthplace (State or Foreign Country)

M.D.

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4615 Park Heights Ave

10f. Zip Code

21215

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.Specify:  
Black15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

Unk

College (1-4 or 5+)

Unk

16. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Unk

16b. Kind of Business/Industry

Unk

17. Father's Name (First, Middle, Last)

Robert Johnson

18. Mother's Name (First, Middle, Maiden Surname)

Cindy Farley

19e. Informant's Name/Relationship (Type, Print)

Cynceray Washington- Social  
Worker

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4615 Park Heights Avenue Baltimore, Md 21215

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Mt. Zion cemetery

Date

01/06/99 Baltimore, Md

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Gabrielle Cook

22. Name and Address of Facility

March F/H West

4300 Wabash Ave, Baltimore Md 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)e. stroke  
Due to (or as a consequence of):Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24e. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation  
6 ☐ Could not be determined

28e. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Usha Sunkara MD

29c. License number

P10432

29d. Date signed (Month, Day, Year)

December 24, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2401 W. Belvedere Avenue Baltimore, Md 21215

31. Date filed (Month, Day, Year)

JAN 8 1999

32. Registrar's Signature

G. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



jhm

State of Maryland / Department of Health and Mental Hygiene

QUILAN

ITEMS: #23 PART I, 27, PER MEO G767

Certificate of Death

Reg. No.

98 41014

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural" for items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Quinlan Tabb Kolb</b>		2. Date of Death Month Day Year <b>DECEMBER 26, 1998</b>		3. Time of Death <b>22:30 PM</b>	
4a. Facility Name (If not institution, give street and number) <b>GREATER BALTIMORE MEDICAL CENTER</b>			4b. City, Town, or Location of Death <b>Towson</b>		4c. County of Death <b>BALTIMORE</b>
5. Social Security Number <b>217-53-2970</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>7 weeks</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Nov. 6 1998</b>
9. Birthplace (State or Foreign Country) <b>Maryland</b>					
Usual Residence of Decedent					
10a. State <b>MD</b>	10b. County <b>Baltimore</b>	10c. City, Town or Location <b>Parkton</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>1305 Molesworth Road</b>		10f. Zip Code <b>21120</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>n/a</b> College (1-4 or 5+) <b>n/a</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>n/a</b>		16b. Kind of Business/Industry <b>n/a</b>	
17. Father's Name (First, Middle, Last) <b>Kenneth Edward Kolb</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Laura Leigh Patrick</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Keneth E. Kolb/father</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1305 Molesworth Road, Parkton, MD 21120</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Dulaney Valley Memorial Gardens</b>		20c. Location - City or Town, State <b>Timonium, MD</b>	
21. Signature of Funeral Service Licensee  <b>Lowell M. Lemmon</b>		22. Name and Address of Facility <b>Lemmon Funeral Home Timonium, MD 21093</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. SUDDEN INFANT DEATH SYNDROME</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):					Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
					24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
					24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29e. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier  <b>J. Pestaner, M.D.</b>		29c. License number <b>OCME</b>		29d. Date signed (Month, Day, Year) <b>DECEMBER 28, 1998</b>	
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) <b>Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201</b>					
31. Date filed (Month, Day, Year) <b>JAN 8 1999</b>		32. Registrar's Signature 			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ITEMS: #4A, 26 PER PHYSICIAN G767 1-8-99 WR **Certificate of Death**

Reg. No.

98 41015

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>Josephine C. Krause</b>				2. Date of Death Month <b>December</b> Day <b>25</b> , Year <b>1998</b>		3. Time of Death <b>6:38 am</b>	
	4a. Facility Name (If not institution, give street and number) <b>12820 Eastern Avenue COZY COUNTRY RETIREMENT HOME</b>				4b. City, Town, or Location of Death <b>Middle River</b>		4c. County of Death <b>Baltimore</b>	
<b>Funeral Director</b>	5. Social Security Number <b>212 22 3815</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>74</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Nov. 9, 1924</b>	
					9. Birthplace (State or Foreign) <b>Maryland</b>			
Usual Residence of Decedent								
10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Middle River</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>1522 Chesapeake Road</b>				10f. Zip Code <b>21220</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Housewife</b>			16b. Kind of Business/Industry <b>Own Home</b>	
17. Father's Name (First, Middle, Last) <b>Carmen Picarello</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>(unknown)</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Anna Minossi</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1522 Chesapeake Road Baltimore Maryland 21220</b>			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Greenmount Crematory</b>		Date <b>12/28/98</b>		20c. Location - City or Town, State <b>Baltimore, Maryland</b>	
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility <b>Bruzdinski Funeral PA 1407 Old Eastern Avenue Essex, Maryland 21221</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
<div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p><b>Hypertensive Arteriosclerotic Cardio</b></p> <p>Due to (or as a consequence of):</p> </div> <div style="width: 60%;"> <p><b>Renal Vascular Disease</b></p> <p>Due to (or as a consequence of):</p> </div> </div>								
<div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> </div> <div style="width: 60%;"> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p> </div> </div>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Home <input checked="" type="checkbox"/> Other (Specify) <b>ASSISTED</b>					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier 					
			29c. License number <b>D-09383</b>		29d. Date signed (Month, Day, Year) <b>December 27, 1998</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Charles F O'Donnell MD Baltimore MD 21210</b>								
31. Date filed (Month, Day, Year) <b>JAN 07 1999</b>			32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

ORIGINAL

200 1 0 420



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 41016

JAVAR MATHIS

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JaVar Pierre Mathis						2. Date of Death Month Day Year DECEMBER 16, 1998		3. Time of Death 4:45A.M.		
	4a. Facility Name (If not institution, give street and number) HOLLY HILL DRIVE				4b. City, Town, or Location of Death ACCOKEEK		4c. County of Death PRINCE GEORGES				
Funeral Director	5. Social Security Number 241-37-6668	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 18 Yrs.	8. Date of Birth (Month, Day, Year) February 4, 1980	9. Birthplace (State or Foreign Country) North Carolina						
	Usual Residence of Decedent										
10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Clinton			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
10e. Street and Number 7111 East Clinton Street				10f. Zip Code 20735		10g. Citizen of What Country? United States of America					
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Stock Clerk			16b. Kind of Business/Industry Merchandise				
17. Father's Name (First, Middle, Last) James P. Mathis						18. Mother's Name (First, Middle, Maiden Surname) Deborah Kenan					
19a. Informant's Name/Relationship (Type, Print) James P. Mathis /Father				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7111 East Clinton Street, Clinton, Maryland 20735							
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Duplin Memorial Gardens		Date January 9, 1999		20c. Location - City or Town, State Teachey, North Carolina					
21. Signature of Funeral Service Licensee <i>Douglas A. Cason</i>				22. Name and Address of Facility Matthews Funeral Service P.O. Box 544, Wallace, North Carolina 28466							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Gunshot Wound of Head</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
								24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) SCENE									
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <i>Found 12/16/98</i>		28b. Time of Injury <i>4:43 AM</i>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <i>subject shot</i>			
		28e. Place of Injury - At home, farm, street, lecture, office building, etc. (Specify) <i>street</i>									
		28f. Location (Street and Number or Rural Route Number, City or Town, State) <i>16100 Holly Hill Drive Accokeek, MD</i>									
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier <i>Dennis J. Chute MD</i>				29c. License number O.C.M.E.			29d. Date signed (Month, Day, Year) DECEMBER 17, 1998				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Dennis J. Chute MD</i> 111 Penn Street, Baltimore, Maryland 21201											
31. Date filed (Month, Day, Year) JAN 8 1999		32. Registrar's Signature <i>B. Sparks</i>									



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 41017

Item#23b,24a per Phy G767 1/8/98 EW

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Patricia McBride					2. Date of Death Month Day Year December 20, 1998			3. Time of Death 4:00 AM		
	4a. Facility Name (If not institution, give street and number) Sunrise Assistant Living					4b. City, Town, or Location of Death Annapolis			4c. County of Death Anne Arundel		
Funeral Director	5. Social Security Number 155-18-9453		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 77 Yrs.		8. Date of Birth (Month, Day, Year) Aug. 22, 1921		9. Birthplace (State or Foreign Country) New Jersey		
	Usual Residence of Decedent					10e. Street and Number 800 Bestgate Road		10f. Zip Code 21410		10g. Citizen of What Country? U.S.A.	
To Be Completed by Funeral Director	10a. State Maryland		10b. County Anne Arundel		10c. City, Town or Location Annapolis			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home					
	17. Father's Name (First, Middle, Last) Stuart Shotwell					18. Mother's Name (First, Middle, Maiden Surname) Beremice Shotwell					
	19a. Informant's Name/Relationship (Type, Print) Tracy McBride/daughter					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1101 Kalmia Court, Crownsville, Maryland 21032					
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date		20c. Location - City or Town, State				
	21. Signature of Funeral Service Licensee Ronald S. Wade Director		22. Name and Address of Facility State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201								
	23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>UroSepsis</u> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Dementia - Meningioma</u> <u>Endometrial Cancer - Colon Cancer</u> <u>Hypertension - Hemiparesis - Surgical</u>										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <u>W. B. Sparks</u>		29c. License number 036488		29d. Date signed (Month/Day, Year) 12/29/98					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WILLIAM E. BEHRNS 3448 HOLLY AVE STE 100 ANNAPOLIS, MD 21401											
31. Date filed (Month, Day, Year) JAN 8 1999		32. Registrar's Signature <u>W. B. Sparks</u>									



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

ITEMS: #17 PER F.H. G768 2-11-99 WR.

Reg. No.

98 41018

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Clara E. Nicely

2. Date of Death

Month Day Year  
Dec 26 1998

3. Time of Death

0632

4a. Facility Name (If not institution, give street and number)

Montgomery General Hosp.

4b. City, Town, or Location of Death

Olney

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

579-28-3381

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
July 19, 1919

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Wheaton

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

12008 Dewey Road

10f. Zip Code

20906

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married

3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Otha Grimsley, Jr. SR.

18. Mother's Name (First, Middle, Maiden Surname)

Mable Wharton

19a. Informant's Name/Relationship (Type, Print)

Patricia Johnson - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12008 Dewey Road Wheaton, MD 20906

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Fairview Cemetery

Date

12/30/98

20c. Location - City or Town, State

Culpeper, Virginia

21. Signature of Funeral Service Licensee

*Karen W. Moore*

22. Name and Address of Facility

Cloze-Geest Funeral Home  
11190 James Monroe Hwy. Culpeper, VA

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. ASCVD

Due to (or as a consequence of):

b. Hypertension

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

DRE

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Seizure disorder

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient

2 ☒ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural

2 ☐ Accident

3 ☐ Suicide

4 ☐ Homicide

5 ☐ Pending investigation

6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*John N. Brecher*

29c. License number

000428

29d. Date signed (Month, Day, Year)

Dec 26, 1998

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

IRA N. BRECHER, MD DMK

2101 Medical Park Dr  
Silver Spring MD 20902

31. Date filed (Month, Day, Year)

JAN 8 1999

32. Registrar's Signature

*Beverly B. Sparks*

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41019

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Marion M. Procelli</b>		2. Date of Death Month <b>December</b> Day <b>31</b> Year <b>1998</b>		3. Time of Death <b>1:00 A.M.</b>	
4a. Facility Name (If not institution, give street and number) <b>Shady Grove Adventist Hospital</b>		4b. City, Town, or Location of Death <b>Rockville</b>		4c. County of Death <b>Montgomery</b>	
5. Social Security Number <b>117-20-8879</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (in yrs. last birthday) <b>72</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>May 12, 1926</b>
9. Birthplace (State or Foreign Country) <b>New York</b>		Usual Residence of Decedent			
10a. State <b>Maryland</b>	10b. County <b>Montgomery</b>	10c. City, Town or Location <b>Gaithersburg</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>18916 Lindenhouse Road</b>		10f. Zip Code <b>20879</b>		10g. Citizen of What Country? <b>United States of America</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>5+</b>			
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Teacher/ Chairman of Business Schools</b>		16b. Kind of Business/Industry <b>Education</b>			
17. Father's Name (First, Middle, Last) <b>Thomas A. Mahoney</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Josephine Wall</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Matthew S. Procelli/ Husband</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>18916 Lindenhouse Road, Gaithersburg, Maryland 20879</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mount Saint Mary's Cemetery</b>		20c. Location - City or Town, State <b>Flushing, New York</b>	
21. Signature of Funeral Service Licensee <b>Howard Hansen</b>		22. Name and Address of Facility <b>Nolan &amp; Taylor-Howe Funeral Home 5 Laurel Avenue, Northport, NY 11768</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>a. non small-cell cancer left lung</b> Due to (or as a consequence of): <b>b.</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>					Approximate Interval Between Onset and Death <b>1 month</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. <b>Alzheimer's Dementia, Hyperthyroidism, osteoporosis</b>					
23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
24b. Were autopsy findings available prior to completion of causa of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			
28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated.					
29b. Signature and title of certifier <b>P. Callahan-Lyon</b>		29c. License number <b>041794</b>		29d. Date signed (Month, Day, Year) <b>December 31, 1998</b>	
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) <b>P. Callahan-Lyon, MD 911 Russell Ave Gaithersburg, MD 20879</b>					
31. Date filed (Month, Day, Year) <b>JAN 8 1999</b>		32. Registrar's Signature <b>B. Sparks</b>			





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41020

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Diana K. Runner				2. Date of Death Month Day Year December 31, 1998				3. Time of Death 2:10 P.M.													
	4a. Facility Name (If not institution, give street and number) Suburban Hospital				4b. City, Town, or Location of Death Bethesda				4c. County of Death Montgomery County													
Funeral Director	5. Social Security Number 171-42-5891		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 49 Yrs.		8. Date of Birth (Month, Day, Year) July 6, 1949		9. Birthplace (State or Foreign Country) Pennsylvania													
	Usual Residence of Decedent																					
10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Germantown				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No														
10e. Street and Number 19440 Zinnia Circle				10f. Zip Code 20874				10g. Citizen of What Country? United States of America														
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White														
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Administrator				16b. Kind of Business/Industry United States Department of Labor														
17. Father's Name (First, Middle, Last) Jack B. Runner				18. Mother's Name (First, Middle, Maiden Surname) Elizabeth A. Brown																		
19a. Informant's Name/Relationship (Type, Print) Larry L. Runner - Brother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 503 Lake View Boulevard, Browns Mills, New Jersey 08015																		
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Rest Haven Memorial Park		Date January 9, 1999		20c. Location - City or Town, State McEchattan, Pennsylvania														
21. Signature of Funeral Service Licensee Howard Carson				22. Name and Address of Facility F.B. Welker Funeral Home 17740 125 North Main Street, Jersey Shore, Pennsylvania																		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																						
<table border="0"> <tr> <td rowspan="4">                 Immediate Cause (Final disease or condition resulting in death)                   Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last             </td> <td>a.</td> <td>Hepatic failure</td> <td>3 days</td> </tr> <tr> <td>b.</td> <td>Metastatic breast cancer</td> <td>42 yrs</td> </tr> <tr> <td>c.</td> <td></td> <td></td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	Hepatic failure	3 days	b.	Metastatic breast cancer	42 yrs	c.			d.		
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	Hepatic failure	3 days																			
	b.	Metastatic breast cancer	42 yrs																			
	c.																					
	d.																					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																						
<table border="0"> <tr> <td colspan="2">Esophageal ulceration</td> <td colspan="2">23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</td> </tr> <tr> <td colspan="2">Acute renal failure</td> <td colspan="2">24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</td> </tr> <tr> <td colspan="2"></td> <td colspan="2">24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</td> </tr> </table>										Esophageal ulceration		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		Acute renal failure		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
Esophageal ulceration		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown																				
Acute renal failure		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																				
		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																		
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No														
				28d. Describe how injury occurred																		
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)																		
				28f. Location (Street and Number or Rural Route Number, City or Town, State)																		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																						
29b. Signature and title of certifier Linda M. Burrell				29c. License number D35996				29d. Date signed (Month, Day, Year) 1/1/99														
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Linda Burrell, 2101 Medical Park Dr #210, Silver Spring, MD																						
31. Date filed (Month, Day, Year) JAN 8 1999				32. Registrar's Signature Geneva B. Sparks																		

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

38 41021

Amend #1, 1/6/99, drw

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner1. Decedent's Name (First, Middle, Last) Sally Louise Christiansen  
Louise ----- Sally ----- Christiansen -----2. Date of Death  
Month Day Year  
Dec 24, 19983. Time of Death  
12:20 PMFuneral  
Director

4a. Facility Name (If not institution, give street and number)

National Lutheran Home

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

5. Social Security Number

579 48 8239

6. Sex  
1 ☐ M 2 ☒ F7. Age (In yrs. last birthday)  
102 Yrs.8. Date of Birth  
(Month, Day, Year)  
Oct 10, 18969. Birthplace (State or Foreign Country)  
Norway

Usual Residence of Decedent

10a. State  
MD10b. County  
Montgomery10c. City, Town or Location  
Rockville10d. Inside City Limits  
1 ☐ Yes 2 ☒ No

10e. Street and Number

9701 Veirs Drive

10f. Zip Code

20850

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No -  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.  
Specify: White15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Assistant Section Chief

16b. Kind of Business/Industry

National Geographic Society

17. Father's Name (First, Middle, Last)

Soren Roed Andersen

18. Mother's Name (First, Middle, Maiden Surname)

Ellen Dorthea Nilsen

19a. Informant's Name/Relationship (Type, Print)

Elliott Thompson (NEPHEW)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9308 Convento Terrace, Fairfax, Virginia 22301

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Lee Crematory Dec 26, 1998

Date

20c. Location - City or Town, State

Clinton, Maryland

21. Signature of Funeral Service Licensee

Charles L. Belanger

22. Name and Address of Facility  
Lee Funeral Home, Inc 6633 Old  
Alexandria Ferry Road, Clinton, Maryland 2073523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Arteriosclerotic cardiovascular disease years

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. Chronic Obstructive pulmonary disease years

c. Atrial fibrillation years

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Advanced senile dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

28. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Charles W. Karesh

29c. License number

D21726

29d. Date signed (Month, Day, Year)

December 24, 1998

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Charles W. Karesh, M.D. 26033 Ridge Road, Damascus, Maryland 20872

31. Date filed (Month, Day, Year)

DEC 30 1998

32. Registrar's Signature

Benita B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

Reg. No. 98 41022

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Giorgio Cimini</b>				2. Date of Death Month <b>December</b> Day <b>25</b> , Year <b>1998</b>				3. Time of Death <b>9:28 PM</b>						
	4a. Facility Name (If not institution, give street and number) <b>Southern Maryland Hospital</b>				4b. City, Town, or Location of Death <b>Clinton</b>				4c. County of Death <b>Prince Georges</b>						
Funeral Director	5. Social Security Number <b>577-56-8500</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>68</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>March 6, 1930</b>		9. Birthplace (State or Foreign Country) <b>Rome Italy</b>						
	Usual Residence of Decedent														
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>Prince George's</b>		10c. City, Town or Location <b>Cheltenham</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
	10e. Street and Number <b>10410 Frank Tippet Road</b>				10f. Zip Code <b>20623</b>		10g. Citizen of What Country? <b>Italy</b>								
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>								
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>N/A</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Tile Setter</b>		16b. Kind of Business/Industry <b>Standard Art, Marble &amp; Terrace Co</b>								
	17. Father's Name (First, Middle, Last) <b>Angelo Cimini</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Cesira Chellini</b>										
	19a. Informant's Name/Relationship (Type, Print) <b>Anna Cimini (Wife)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10410 Frank Tippet Road Cheltenham, MD 20623</b>										
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Resurrection Cemetery</b>		Date <b>Dec. 29, 1998</b>		20c. Location - City or Town, State <b>Clinton, Maryland</b>								
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Rd Clinton, MD 20735</b>										
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Pulmonary thromboemboli</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
										24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		26. Place of Death (Check only one) Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)											
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <b>Sept. 1998</b>		28b. Time of Injury <b>unknown</b> M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>Subject fell from tree while doing yard work</b>				28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>10410 Frank Tippet Rd Prince Georges County, Maryland</b>			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										29b. Signature and title of certifier 		29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>December 26, 1998</b>	
30. Name and address of person who completed cause of death (Item 28f) (Type, Print) <b>Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201</b>															
31. Date filed (Month, Day, Year) <b>DEC 30 1998</b>		32. Registrar's Signature 													





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41023

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Josephine Elizabeth Dill

2. Date of Death

Month Day Year  
Dec. 31 1998

3. Time of Death

10 AM est

4a. Facility Name (If not institution, give street and number)

303 N. Church Street

4b. City, Town, or Location of Death

Greensboro

4c. County of Death

Caroline

Funeral  
Director

5. Social Security Number

218-12-1886

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
June 15 1908

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Caroline

10c. City, Town or Location

Greensboro

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

303 N. Church Street

10f. Zip Code

21639

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10 yrs

College (14 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

seamstress

16b. Kind of Business/Industry

manufacturing

17. Father's Name (First, Middle, Last)

August Brogley

18. Mother's Name (First, Middle, Maiden Surname)

Lena Kibler Brogley

19a. Informant's Name/Relationship (Type, Print)

Gladys Kinnamon/ daughter-in-law

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 264 Greensboro, Maryland 21639

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Greensboro Cemetery

Date

1/5/99

20c. Location - City or Town, State

Greensboro, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Fleegle & Helfenbein Funeral Home. PA  
P.O. Box 160 Greensboro, MD 2163923a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. ACUTE CARDIOPULMONARY ARREST

Due to (or as a consequence of):

b. CHRONIC CONGESTIVE CARDIAC FAILURE

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

ACUTE

CHRONIC

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?  
1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
2 ☐ Accident investigation  
3 ☐ Suicide 6 ☐ Could not be  
4 ☐ Homicide determined

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

26d. Describe how injury occurred

28t. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D14664

29d. Date signed (Month, Day, Year)

1/4/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

C.E. JENSEN MD, BOX 690, DENTON MD 21629

31. Date filed (Month, Day, Year)

JAN - 4 1999

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41024

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Edward Luther Dove, Jr.</b>				2. Date of Death Month <b>Dec</b> Day <b>25</b> Year <b>1998</b>		3. Time of Death <b>0100</b>	
	4a. Facility Name (If not institution, give street and number) <b>Shore Nursing &amp; Rehab Center</b>				4b. City, Town, or Location of Death <b>Denton</b>		4c. County of Death <b>Caroline</b>	
Funeral Director	5. Social Security Number <b>217-14-7471</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>87</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Sept 16 1911</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>Prince George</b>		10c. City, Town or Location <b>Ft. Washington</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number <b>7008 Pleasant Hill Drive</b>		10f. Zip Code <b>207</b>	
	10g. Citizen of What Country? <b>USA</b>				11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>College (14 or 5+)</b>	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>farmer</b>				16b. Kind of Business/Industry <b>tobacco</b>			
	17. Father's Name (First, Middle, Last) <b>Edward L. Dove, Sr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Edith V. Anderson Dove</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>William Dove/ brother</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9794 Tuckahoe Road, Denton, Maryland 21629</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Greensboro Cemetery</b>		20c. Location - City or Town, State <b>12/27 Greensboro, Maryland</b>		21. Signature of Funeral Service Licensee 	
	22. Name and Address of Facility <b>Fleegle &amp; Helfenbein Funeral Home, PA Box 160 Greensboro, Maryland 21639</b>				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>CNF</b>			
	23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicida <input type="checkbox"/> Homicida <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				
28a. Date of Injury (Month, Day Year)				28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 				
29c. License number <b>D32036</b>				29d. Date signed (Month, Day, Year) <b>12/27/98</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Gary J. Sprouse 2108 P. Deneh Drive Chester, Md 21619</b>				31. Data filed (Month, Day, Year) <b>JAN - 4 1999</b>				
32. Registrar's Signature 				State Registrar				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

98 41025

Amend #12, 28 years, 1/6/99, drw

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) George R. Donley				2. Date of Death Month Day Year DECEMBER 24, 1998				3. Time of Death 3:10 P.M.		
	4a. Facility Name (If not institution, give street and number) MALCOLM GROW MEDICAL CENTER				4b. City, Town, or Location of Death CAMP SPRINGS				4c. County of Death PRINCE GEORGE'S		
Funeral Director	5. Social Security Number 579 52 2089		8. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 88 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		
	6. Date of Birth (Month, Day, Year) July 30, 1910		9. Birthplace (State or Foreign Country) Pennsylvania		10. Usual Residence of Decedent 10a. State MD 10b. County P.G. 10c. City, Town or Location Suitland 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 4410 Ridgecrest Drive		10f. Zip Code 20746		
To Be Completed by Funeral Director		11. Marital Status 1 <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Date: 1942 1956 28 years		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 2	
		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Colonel		16b. Kind of Business/Industry U.S. Air Force		17. Father's Name (First, Middle, Last) George Raymond Donley		18. Mother's Name (First, Middle, Maiden Surname) Anna Lieber		19a. Informant's Name/Relationship (Type, Print) Dorothy L. Donley (WIFE)	
To Be Completed by Physician/Medical Examiner		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4410 Ridgecrest Drive, Suitland, Maryland 20746		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veterans Cemetery		20c. Location - City or Town, State Cheltenham, Maryland		21. Signature of Funeral Service Licensee Charles L. Belanger	
		22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, MD 20735		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. STAGE DUKES TWO PROSTATE CANCER METASTATIC TO BONE Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):		Approximate Interval Between Onset and Death 3 YEARS		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
To Be Completed by Physician/Medical Examiner		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined	
		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
To Be Completed by Physician/Medical Examiner		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Alan Perlman		29c. License number PA MD- 058405- L		29d. Date signed (Month, Day, Year) DECEMBER 24, 1998	
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ALAN PERLMAN, CAPT, USAF, MC 89 MDG/1050 W PERIMETER RD ANDREWS AIR FORCE BASE, MD 20762-6600		31. Date filed (Month, Day, Year) DEC 30 1998		32. Registrar's Signature Benita B. Sparks		33. State Registrar		34. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 41026

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Alyce Duthie</b>				2. Date of Death Month Day Year <b>DECEMBER 27, 1998</b>				3. Time of Death <b>03:15PM</b>					
	4a. Facility Name (If not Institution, give street and number) <b>SOUTHERN MARYLAND HOSPITAL CENTER</b>				4b. City, Town, or Location of Death <b>CLINTON</b>				4c. County of Death <b>PRINCE GEORGES</b>					
Funeral Director	5. Social Security Number <b>579 05 3895</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>93</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Aug 20, 1905</b>		9. Birthplace (State or Foreign Country) <b>Michigan</b>					
	Usual Residence of Decedent													
To Be Completed by Funeral Director	10a. State <b>MD</b>		10b. County <b>P.G.</b>		10c. City, Town or Location <b>Brandywine</b>				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
	10e. Street and Number <b>12201 Cedarville Road</b>				10f. Zip Code <b>20613</b>				10g. Citizen of What Country? <b>UNITED STATES</b>					
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify <b>White</b>					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Hostess</b>				16b. Kind of Business/Industry <b>Union Station</b>					
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>Adelbert O. Cook</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Emma Wilcox</b>									
	19a. Informant's Name/Relationship (Type, Print) <b>Keith Sherwood (FRIEND)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>12201 Cedarville Rd, Brandywine, Maryland 20613</b>									
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Lee Crematory</b>				20c. Location - City or Town, State <b>December 29, 1998 Clinton, Maryland</b>					
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735</b>									
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. ASPHYXIA (CHOKED ON BOLLUS OF FOOD)</b> Due to (or as a consequence of): <b>b. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>													
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown													
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No													
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No													
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.													
	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
	27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year) <b>12-27-98</b>		28b. Time of Injury <b>02:40PM</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>CHOKED ON BOLLUS OF FOOD</b>			
	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>HOME</b>				28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>12201 CEDERVILLE ROAD, MARYLAND</b>					
State Registrar	29b. Signature and title of certifier: 				29c. License number <b>D 33954</b>				29d. Date signed (Month, Day, Year) <b>DECEMBER 28, 1998</b>					
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MARIO F. GOLLE JR 3001 HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785</b>													
31. Date filed (Month, Day, Year) <b>DEC 30 1998</b>														
32. Registrar's Signature 														



1. The first part of the report is a general  
introduction to the subject of the study.  
It is a very important part of the report  
and should be written in a clear and concise  
manner.

2. The second part of the report is a  
description of the methods used in the study.  
This part should be written in a clear and  
concise manner and should include a detailed  
description of the experimental procedures.

3. The third part of the report is a  
description of the results of the study.  
This part should be written in a clear and  
concise manner and should include a detailed  
description of the data obtained.

4. The fourth part of the report is a  
discussion of the results of the study.  
This part should be written in a clear and  
concise manner and should include a detailed  
description of the conclusions drawn from the  
results.

5. The fifth part of the report is a  
conclusion to the study.  
This part should be written in a clear and  
concise manner and should include a detailed  
description of the overall findings of the study.

6. The sixth part of the report is a  
list of references.  
This part should be written in a clear and  
concise manner and should include a detailed  
description of the sources used in the study.

7. The seventh part of the report is a  
list of appendices.  
This part should be written in a clear and  
concise manner and should include a detailed  
description of the additional material included  
in the report.

8. The eighth part of the report is a  
list of figures.  
This part should be written in a clear and  
concise manner and should include a detailed  
description of the figures included in the  
report.

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41027

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Howe E. Easton				2. Date of Death December 22, 1998		3. Time of Death 9:20 P.M.		
	4a. Facility Name (If not institution, give street and number) Spa Creek Center				4b. City, Town, or Location of Death Annapolis		4c. County of Death Anne Arundel		
Funeral Director	5. Social Security Number 218-14-3041	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 77 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) May 9, 1921		9. Birthplace (State or Foreign) Maryland	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State Maryland		10b. County Anne Arundel		10c. City, Town or Location Shady Side		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 5966 Shady Side Road				10f. Zip Code 20764		10g. Citizen of What Country? USA		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Farmer		16b. Kind of Business/Industry Farming				
	17. Father's Name (First, Middle, Last) Richard Easton				18. Mother's Name (First, Middle, Maiden Surname) Helen Young				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Lucille Easton/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5966 Shady Side Road Shady Side, MD 20764				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Bethel Way of the Cross		Data 12/28/98		20c. Location - City or Town, State Huntingtown, MD		
	21. Signature of Funeral Service Licensee Blodys A. Sewell				22. Name and Address of Facility Sewell Funeral Home 1451 Dares Beach Road Prince Frederick, MD 20678				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. RENAL FAILURE Due to (or as a consequence of): b. DIABETES, ADULT onset Due to (or as a consequence of): c. { Due to (or as a consequence of): d. { Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death 5 yr 20 yr	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CORONARY ARTERY DISEASE CONGESTIVE HEART FAILURE							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
			28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier Harvey J. Steinfeld MD		29c. License number D05158		29d. Date signed (Month, Day, Year) DEC 23, 1998				
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HARVEY J STEINFELD, SHADYSIDE, MD 20764				31. Date filed (Month, Day, Year) DEC 28 1998				
	32. Registrar's Signature B. Sparks								



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41028

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>DONALD CARL GATEWOOD, SR</b>				2. Date of Death Month <b>December</b> Day <b>27</b> Year <b>1998</b>		3. Time of Death <b>2200 P.M.</b>		
	4a. Facility Name (If not institution, give street and number) <b>Calvert Memorial Hospital</b>				4b. City, Town, or Location of Death <b>Prince Frederick</b>		4c. County of Death <b>Calvert</b>		
Funeral Director	5. Social Security Number <b>579-30 0636</b>		8. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>70</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>January 18, 1928</b>		
	9. Birthplace (State or Foreign Country) <b>Washington, DC</b>								
To Be Completed by Funeral Director	Usual Residence of Decedent		10a. State <b>Maryland</b>		10b. County <b>Calvert</b>		10c. City, Town or Location <b>Huntingtown</b>		
	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
	10e. Street and Number <b>3571 Deep Landing Road</b>		10f. Zip Code <b>20639-9554</b>		10g. Citizen of What Country? <b>United States</b>				
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1946</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Distributor</b>		16b. Kind of Business/Industry <b>Newspaper</b>				
	17. Father's Name (First, Middle, Last) <b>Lambert Lutrell Gatewood</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Louise Emma Mayer</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>Gloria V. Gatewood, /wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>same as 10</b>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Asbury Cemetery</b>		Date <b>12/30/98</b>		20c. Location - City or Town, State <b>Barstow, Maryland</b>		
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, POB 100, Owings, MD 20736</b>						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <div style="display: flex; align-items: center;"> <div style="font-size: 4em; margin-right: 10px;">{</div> <div> <p>s. <b>VENTRICULAR FIBRILLATION</b> Due to (or as a consequence of):</p> <p>b. <b>Ischemic Cardiomyopathy</b> Due to (or as a consequence of):</p> <p>c. <b>Coronary Artery Disease</b> Due to (or as a consequence of):</p> <p>d.</p> </div> </div>								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown									
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier 				29c. License number <b>D 22615</b>		29d. Date signed (Month, Day, Year) <b>December 27, 1998</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Ronald J. Ross, MD Calvert Memorial Hospital, Prince Frederick, MD 20678</b>									
31. Date filed (Month, Day, Year) <b>DEC 30 1998</b>		32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41029

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Richard Thomas Grimes

2. Date of Death

Dec 29, 1998

3. Time of Death

4:30 A.M.

Funeral  
Director

4e. Facility Name (If not institution, give street and number)

5508 Yorkshire Drive

4b. City, Town, or Location of Death

Temple Hills

4c. County of Death

Prince George's

5. Social Security Number

577 60 2724

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

93

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Dec 4, 1905

9. Birthplace (State or Foreign Country)

Washington DC

Usual Residence of Decedent

10a. State

MD

10b. County

P.G.

10c. City, Town or Location

Temple Hills

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

5508 Yorkshire Drive

10f. Zip Code

20748

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Chief Cartologist

16b. Kind of Business/Industry

U.S. Postal Service

17. Father's Name (First, Middle, Last)

Henry T. Grimes

18. Mother's Name (First, Middle, Maiden Surname)

Lillian A. Haar

19a. Informant's Name/Relationship (Type, Print)

Ann Grimes (WIFE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5508 Yorkshire Drive, Temple Hills, MD 20748

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Hill Cemetery Jan 2, 1998 Suitland, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a.

ACUTE MYOCARDIAL INFARCTION

Due to (or as a consequence of):

b.

ARTERIOSCLEROTIC HEART DISEASE

Due to (or as a consequence of):

c.

ARTERIOSCLEROTIC CEREBROVASCULAR DIS.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter underlying cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CERVICAL SPONDYLOSIS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28t. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

R. A. McConaughy MD

29c. License number

D07287

29d. Date signed (Month, Day, Year)

Dec 29, 98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

R. A. McConaughy, M.D. 11418 Livingston Rd, Fort Washington, MD20744

31. Date filed (Month, Day, Year)

DEC 30 1998

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 41030

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>PAUL MILLARD GINGRICH</b>						2. Date of Death Month Day Year <b>DECEMBER 23, 1998</b>		3. Time of Death <b>04:30</b>			
	4a. Facility Name (If not institution, give street and number) <b>CALVERT MEMORIAL HOSPITAL</b>						4b. City, Town, or Location of Death <b>PRINCE FREDERICK</b>		4c. County of Death <b>CALVERT</b>			
Funeral Director	5. Social Security Number <b>206-10-9825</b>		6. Sex <b>1</b> M <b>2</b> F		7. Age (In yrs. last birthday) <b>78</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>JAN. 16, 1920</b>		9. Birthplace (State or Foreign Country) <b>PENNSYLVANIA</b>			
	Usual Residence of Decedent						10a. State <b>MARYLAND</b>		10b. County <b>CALVERT</b>		10c. City, Town or Location <b>OWINGS</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <b>1</b> Yes <b>2</b> No						10e. Street and Number <b>2320 DUNKIRK DRIVE</b>		10f. Zip Code <b>20736</b>		10g. Citizen of What Country? <b>U. S. A.</b>	
	11. Marital Status <b>1</b> Never Married <b>2</b> Married <b>3</b> Widowed <b>4</b> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <b>1</b> Yes <b>2</b> No If Yes, Give Year or Dates: <b>W.W.II</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> Yes <b>2</b> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>CREDIT MANAGER</b>		16b. Kind of Business/Industry <b>FIRESTONE TIRE</b>							
	17. Father's Name (First, Middle, Last) <b>WILLIAM E. GINGRICH</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>EVA HULL</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>JANET G. JACOBS/DAUGHTER</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2320 DUNKIRK DRIVE OWINGS, MARYLAND 20736</b>					
	20a. Method of Disposition <b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State <b>4</b> Donation <b>5</b> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>LEE CREMATORY</b>		20c. Date <b>DECEMBER 24, 1998</b>		20d. Location - City or Town, State <b>CLINTON, MARYLAND</b>					
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>LEE FUNERAL HOME CALVERT, P.A. 8125 SOUTHERN MD BLVD. OWINGS, MARYLAND 20736</b>									
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <b>pneumonia</b> Due to (or as a consequence of): b. <b>severe disorder</b> Due to (or as a consequence of): c. <b>cardiovascular disease</b> Due to (or as a consequence of): d.  Approximate Interval Between Onset and Death <b>3 days</b> <b>2 weeks</b> <b>3 years</b>											
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown			
									24a. Was an autopsy performed? <b>1</b> Yes <b>2</b> No			
								24b. Were autopsy findings available prior to completion of cause of death? <b>1</b> Yes <b>2</b> No				
25. Was case referred to medical examiner? <b>1</b> Yes <b>2</b> No		26. Place of Death (Check only one) Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify)										
27. Manner of Death <b>1</b> Natural <b>5</b> Pending investigation <b>2</b> Accident <b>6</b> Could not be determined <b>3</b> Suicide <b>4</b> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <b>1</b> Yes <b>2</b> No		28d. Describe how injury occurred				
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <b>1</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>046314</b>		29d. Date signed (Month, Day, Year) <b>12/23/98</b>						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. Paul v. Pomilla, M.D. Prince Frederick, MD 20657</b>												
31. Date filed (Month, Day, Year) <b>DEC 28 1998</b>		32. Registrar's Signature 										

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 41031

ITEMS: #5 PER F.H. G767 1-15-99 WR.

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>VIRGINIA CHARITY HOSELRODE</b>				2. Date of Death Month Day Year <b>December 24, 1998</b>		3. Time of Death <b>1732</b>	
	4a. Facility Name (If not Institution, give street and number) <b>Calvert Memorial Hospital</b>				4b. City, Town, or Location of Death <b>Pr. Frederick</b>		4c. County of Death <b>Calvert</b>	
Funeral Director	5. Social Security Number <b>578-54-3379</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>56</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>12/2/42</b>	9. Birthplace (State or Foreign Country) <b>Leesburg, VA</b>
	Usual Residence of Decedent							
10a. State <b>MD</b>		10b. County <b>Calvert</b>		10c. City, Town or Location <b>Huntingtown</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>4040 Hidden Hill Drive</b>				10f. Zip Code <b>20639</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>1</b> Collega (1-4or 5+)				18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Computer Programmer</b>			16b. Kind of Business/Industry <b>civil engineering</b>	
17. Father's Name (First, Middle, Last) <b>John Shelby Cole</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Charity Bolt</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Edward Hoselrode/spouse</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4040 Hidden Hill Drive, Huntingtown, MD</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <b>entombment</b>				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>S. Memorial Gardens</b>		20c. Location - City or Town, State <b>12/30/98 Dunkirk, MD</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Raymond Funeral Home P.O. Box 121, Dunkirk, MD 20754</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediata Causa (Final disease or condition resulting in death)  a. <b>Carcinoma of the Larynx</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediata causa. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner		28. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
29b. Signature and title of certifier 				29c. License number <b>047610</b>		29d. Date signed (Month, Day, Year) <b>December 24 1998</b>		
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) <b>DR. DAVID J TARDIO, M.D. Prince Frederick, Maryland 20678</b>								
31. Date filed (Month, Day, Year) <b>DEC 28 1998</b>		32. Registrar's Signature 						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

20



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

88 41032

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Carolyn Lankford Ireland</b>				2. Date of Death Month <b>Dec</b> Day <b>26</b> Year <b>1998</b>		3. Time of Death	
4a. Facility Name (If not institution, give street and number) <b>13530 Olivet Road</b>				4b. City, Town, or Location of Death <b>Lusby</b>		4c. County of Death <b>Calvert</b>	
5. Social Security Number <b>220 16 5383</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>73</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Nov 27 1925</b>	
9. Birthplace (State or Foreign Country) <b>Maryland</b>							
Usual Residence of Decedent				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
10a. State <b>Maryland</b>		10b. County <b>Calvert</b>		10c. City, Town or Location <b>Lusby</b>			
10e. Street and Number <b>13530 Olivet Road</b>				10f. Zip Code <b>20657</b>		10g. Citizen of What Country? <b>United States</b>	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>2</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>homemaker</b>		16b. Kind of Business/Industry <b>own home</b>	
17. Father's Name (First, Middle, Last) <b>Eugene Lankford</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Alice R. Glover</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Lynda Ireland- daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>13530 Olivet Rd. Lusby, MD 20657</b>			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Olivet Cemetery</b>		Date <b>Dec 29 1998</b>		20c. Location - City or Town, State <b>Lusby Maryland</b>	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Rausch Funeral Home PA</b> <b>4405 Broomes Is. Rd. Port Republic MD 20676</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <b>RENAL FAILURE</b> a. Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):						Approximate interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <b>CHRONIC RESPIRATORY FAILURE</b>  <b>SEIZURE DISORDER</b>						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day Year)		28b. Time of injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier 				29c. License number <b>D 40370</b>		29d. Date signed (Month, Day, Year) <b>Dec 28 1998</b>	
30. Name and address of person who completed cause of death (item 23a) (Type, Print) <b>Peter L. Wisniewski, M.D. 110 Hospital Rd. Suite 310 Prince Frederick MD 20678</b>							
31. Date filed (Month, Day, Year) <b>DEC 28 1998</b>				32. Registrar's Signature 			

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend #19A, Alice E., 12/29/98, drw

Certificate of Death

Reg. No.

98 41033

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

JOE BRADFORD JONES

2. Date of Death

Month Day Year  
December 22 1998

3. Time of Death

5:00 a.m.

4a. Facility Name (If not institution, give street and number)

1105 Doris Drive

4b. City, Town, or Location of Death

Owings

4c. County of Death

Calvert

5. Social Security Number

260 54 4824

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

63 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Dec. 8, 1935

9. Birthplace (State or Foreign Country)

Georgia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Calvert

10c. City, Town or Location

Owings

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1105 Doris Drive

10f. Zip Code

20736

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates: 1958-7913. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Facility Manager

16b. Kind of Business/Industry

Printing

17. Father's Name (First, Middle, Last)

Ollie

Jones

18. Mother's Name (First, Middle, Maiden Surname)

Margree

Carnes

19a. Informant's Name/Relationship (Type, Print)

Alice E. Betty Sunderland Jones/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

same as 10 above

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Mt. Harmony Cemetery

Date

12-24-98 Owings, MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

William R. Jones

22. Name and Address of Facility

Rausch Funeral Home, P.A., Owings, MD 20736

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

Prostate Adenocarcinoma and Multiple

1 year

Due to (or as a consequence of):

Bone / Pulmonary Metastases

1 year

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Obstructive Lung Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)29b. Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Gerald P. Sterner MD

29c. License number

D 17245

29d. Date signed (Month, Day, Year)

December 22, 1998

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Gerald P. Sterner M.D.

Owings, Md. 20736

31. Date filed (Month, Day, Year)

DEC 28 1998

32. Registrar's Signature

Benita B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

IRENE KRALY

2. Date of Death

Month Day Year  
DECEMBER 18, 98

3. Time of Death

7:20pm

4a. Facility Name (If not Institution, give street and number)

2505 Oak Glen Way

4b. City, Town, or Location of Death

Forestville

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

168-22-3723

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

72 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

March 23, 1926

9. Birthplace (State or Foreign Country)

Rankin, PA

Usual Residence of Decedent

10a. State

MD

10b. County

P.G.

10c. City, Town or Location

Forestville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2505 Oak Glen Way

10f. Zip Code

20747

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Frank Cirbus

18. Mother's Name (First, Middle, Maiden Summa)

Susan Kocik

19a. Informant's Name/Relationship (Type, Print)

Susan Vanhorenbeck (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2505 Oak Glen Way, Forestville, Maryland 20747

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Braddock Catholic Cemetery

Dec 22, 1998

20c. Location - City or Town, State

Braddock Hills, PA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Lee Funeral Home, '6633 Old  
Alexandria Ferry Road, Clinton, Maryland 20735

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Colon cancer

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 0023600

29d. Date signed (Month, Day, Year)

12/19/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bruce R. Kressel, M.D. 2141 K. Street, N.W. Suite 707, Washington DC 20037

31. Date filed (Month, Day, Year)

DEC 30 1998

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend #1, McMillan, 12/30/98, drw

Certificate of Death

Reg. No.

98 41035

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

VIRGINIA McMILLAN McMillan

2. Date of Death

Dec 27 1998

3. Time of Death

20:26

4a. Facility Name (If not institution, give street and number)

Howard County General Hospital

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

Funeral  
Director

5. Social Security Number

220-42-2652

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

62

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

April 12, 1936

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Georgia

10b. County

10c. City, Town or Location

Atlanta

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

430 Techwood Drive NW #C803

10f. Zip Code

30313

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No -  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working  
life. DO NOT use retired)

Domestic

16b. Kind of Business/Industry

Someone else's home

17. Father's Name (First, Middle, Last)

Leroy

Brogden

18. Mother's Name (First, Middle, Maiden Surname)

America

Gross

19a. Informant's Name/Relationship (Type, Print)

Paulette Creek/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1516 Cox Road Huntingtown, MD 20639

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Ernestine Jones Cem.

Date

1/2/99

20c. Location - City or Town, State

Chesapeake Beach, MD

21. Signature of Funeral Service Licensee

Blacks &amp; Sowell

22. Name and Address of Facility

Sewell Funeral Home

1451 Dares Beach Road Prince Frederick, MD 20678

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Atherosclerotic Cardiovascular Disease

years

Due to (or as a consequence of):

b. Hypertension

years

Due to (or as a consequence of):

c. Diabetes mellitus

years

Due to (or as a consequence of):

d. Severe Anemia

years?  
unknownSequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Patryce A. Tye, MD ME

29c. License number

D31473

29d. Date signed (Month, Day, Year)

Dec 28, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PATRYCE A. TYE, MD 4565 Hemlock Cone Way Ellicott City MD 21042

31. Date filed (Month, Day, Year)

DEC 30 1998

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

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2014-2015  
2016-2017  
2018-2019  
2020-2021  
2022-2023  
2024-2025

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41036

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

John Edward Morrow, Jr.

2. Date of Death

Dec. 25, 1998

3. Time of Death

6:00AM

4a. Facility Name (If not institution, give street and number)

6805 Farragut Street

4b. City, Town, or Location of Death

Hyattsville

4c. County of Death

Prince George

5. Social Security Number

577 05 9253

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

80

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Aug 25, 1918

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

Md.

10b. County

Prince George

10c. City, Town or Location

Hyattsville

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

6805 Farragut Street

10f. Zip Code

20784

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

XX Yes 2 ☐ No  
If Yes, Give Year or Dates: 1942  
1945

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Manager

16b. Kind of Business/Industry

Peoples Drug Store

17. Father's Name (First, Middle, Last)

John Edward Morrow, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Trinnie Smith

19a. Informant's Name/Relationship (Type, Print)

Katharine Morrow (WIFE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6805 Farragut Street, Hyattsville, Maryland 20784

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Hill Cemetery Dec 29, 1998 Suitland, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Acute myocardial infarction* (3) hours  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*Hypertension*  
*S/P Cerebrovascular accident*  
*Chronic renal failure*

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 20824

29d. Date signed (Month, Day, Year)

12/28/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Glen (Junction) 9450 Penn Ave #18 Upper Marlboro, MD

31. Date filed (Month, Day, Year)

DEC 30 1998

32. Registrar's Signature

B. Sparks

20772

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41037

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Sue Brown Mayhew				2. Date of Death Month Day Year Dec 17, 1998				3. Time of Death 12:45 AM	
	4a. Facility Name (If not institution, give street and number) 4613 Omaha Street				4b. City, Town, or Location of Death Capital Heights				4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 579-07-2332		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 85 Yrs.		8. Date of Birth (Month, Day, Year) March 2, 1913		9. Birthplace (State or Foreign Country) Virginia	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD		10b. County Prince George's		10c. City, Town or Location Capital Heights				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 4613 Omaha Street				10f. Zip Code 20743		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clothing Buyer			16b. Kind of Business/Industry Jelleffs Department Store				
	17. Father's Name (First, Middle, Last) Ali Pickeral				18. Mother's Name (First, Middle, Maiden Surname) Tensie Glenn Pickeral					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Isaac Mayhew Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4613 Omaha Street, Capital Heights, MD 20743					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Mayhew Family Cemetery		20c. Location - City or Town, State Gretna, Virginia			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Lee Funeral Home Inc. 6633 Old Alexander Ferry Rd., Clinton, MD 20735					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				a. multiple cardiovascular accidents Due to (or as a consequence of):				Approximate Interval Between Onset and Death mos	
	b. Atherosclerotic cardiovascular disease Due to (or as a consequence of):				c. Due to (or as a consequence of):				yes	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier 		29c. License number D19431		29d. Date signed (Month, Day, Year) 12/17/98		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Frank M. Ryan M.D. 1701 Livingston Rd #205 Ft. Washington MD 20744										
31. Date filed (Month, Day, Year) DEC 30 1998				32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41038

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

FREDIA

MORELAND

2. Date of Death

Month Day Year  
DECEMBER 21, 1998

3. Time of Death

04:10

4a. Facility Name (If not institution, give street and number)

Calvert Memorial Hospital

4b. City, Town, or Location of Death

Prince Frederick

4c. County of Death

Calvert

5. Social Security Number

578 72 0256

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

61

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
June 5, 1937

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Calvert

10c. City, Town or Location

Barstow

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

90 Barstow Road

10f. Zip Code

20610

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

homemaker

16b. Kind of Business/Industry

own home

17. Father's Name (First, Middle, Last)

Everett Randolph Boone

18. Mother's Name (First, Middle, Maiden Surname)

Myrtle Jane Persinger

19a. Informant's Name/Relationship (Type, Print)

Jane A. Persinger / daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 69, Barstow, MD 20610

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☒ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Elk Knob Cemetery

Date

12-26-98

20c. Location - City or Town, State

Judson, WV

21. Signature of Funeral Service Licensee

William R. Gross

22. Name and Address of Facility

Rausch Funeral Home, P.A., Owings, MD 20736

23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE RESPIRATORY FAILURE

3 days

Due to (or as a consequence of):

b. CONGESTIVE HEART FAILURE

3 days

Due to (or as a consequence of):

c. COR PULMONALE

Years

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Dr. Atul R. Shah, M.D.

29c. License number

D-025519

29d. Date signed (Month, Day, Year)

12-21-98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Atul R. Shah, M.D. Prince Frederick, MD 20678

31. Date filed (Month, Day, Year)

DEC 28 1998

32. Registrar's Signature

Benita B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41039

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JEAN INGELO MOORE</b>				2. Date of Death Month <b>12</b> Day <b>28</b> Year <b>1998</b>		3. Time of Death <b>8:50 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>SUNRISE ASSISTED LIVING CENTER</b>				4b. City, Town, or Location of Death <b>ANNAPOLIS</b>		4c. County of Death <b>AA</b>	
Funeral Director	5. Social Security Number <b>213 36 0777</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>82</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>3/23/1916</b>	9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>
	Usual Residence of Decedent							
10a. State <b>MD</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Annapolis</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>800 Bestgate Road</b>				10f. Zip Code <b>21401</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>4</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>		
17. Father's Name (First, Middle, Last) <b>Carl Irwin</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Martha Williams</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Thomas Moore (son)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3203 Breckenridge Way/Riva Md 21140</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metropolitan Crematory</b>		Date <b>12/29/98</b>		20c. Location - City or Town, State <b>Alexandria VA</b>	
21. Signature of Funeral Service Licensee <b>Wilhelm Wagon</b>				22. Name and Address of Facility <b>Advent Funeral &amp; Cremation Services Annapolis MD 21401</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <b>Congestive Heart Failure</b> Due to (or as a consequence of): b. <b>Hypertensive Cardiomyopathy</b> Due to (or as a consequence of): c. <b>Hypertension</b> Due to (or as a consequence of): d.  Approximate Interval Between Onset and Death <b>2 years</b> <b>years</b>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Atrial fib</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Assisted Living</b>						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <b>James Ruppel MD</b>				29c. License number <b>D 25499</b>		29d. Date signed (Month, Day, Year) <b>12/28/98</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>James Ruppel 180 Admiral Cochrane Dr Annapolis, MD 21401</b>								
31. Date filed (Month, Day, Year) <b>JAN 08 1999</b>		32. Registrar's Signature <b>James B. Spaw</b>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41040

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Margaret Gallagher Peix

2. Date of Death

Month Day Year  
December 29 1998

3. Time of Death

4:00 am

4a. Facility Name (If not institution, give street and number)

12115 Greensboro Rd.

4b. City, Town, or Location of Death

Greensboro

4c. County of Death

Caroline

Funeral  
Director

5. Social Security Number

072-12-1261

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

92

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Sept. 23, 1906

9. Birthplace (State or Foreign Country)

Conn.

Usual Residence of Decedent

10a. State

Md.

10b. County

Caroline

10c. City, Town or Location

Greensboro

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

12115 Greensboro Rd. Greensboro

10f. Zip Code

21639

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Teacher

16b. Kind of Business/Industry

public school

17. Father's Name (First, Middle, Last)

Thomas Gallagher

18. Mother's Name (First, Middle, Maiden Summa)

Carie Bell Gallagher

19a. Informant's Name/Relationship (Type, Print)

Richard T. Peix (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12115 Greensboro Rd. Greensboro Md. 21639

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Chesapeake Cremation Ctr. 12-29-98 Chester Md.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

*[Signature]*

22. Name and Address of Facility

Fleegle-Helfenbein F.H. P.O. Box 160  
Greensboro Md. 21639

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. metastatic colon cancer

Due to (or as a consequence of):

Approximate interval Between Onset and Death

years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

diabetes mellitus

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*[Signature]* MD.

29c. License number

D47534

29d. Date signed (Month, Day, Year)

12/29/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W. Zaki, MD 920 E. Market Street Denton, MD 21629

31. Date filed (Month, Day, Year)

DEC 30 1998

32. Registrar's Signature

*[Signature]*

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 41041

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

RICHARD CARL RAUSCH SR

2. Date of Death  
Month Day Year  
DECEMBER 20 1998

3. Time of Death  
3:15 AM

4a. Facility Name (If not institution, give street and number)

SALISBURY CENTER: GENESIS ELDERCARE

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

Funeral  
Director

5. Social Security Number  
216 18 5172

6. Sex  
1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)  
82 Yrs.

If Under 1 Year  
Months Days

If Under 24 Hrs.  
Hours Min.

8. Date of Birth  
(Month, Day, Year)  
Oct 28, 1916

9. Birthplace (State or Foreign Country)  
Annapolis, MD

Usual Residence of Decedent

10a. State  
Maryland

10b. County  
Wicomico

10c. City, Town or Location

Parsonsbury

10d. Inside City Limits  
1 ☐ Yes 2 ☒ No

10e. Street and Number

9017 Whiteville Road

10f. Zip Code

21849

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.  
Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: 1942-45

13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,  
Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)  
11

College (1-4 or 5+)

18e. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Test mechanic

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

Martin William Rausch

18. Mother's Name (First, Middle, Maiden Surname)

Mabel

Howard

19a. Informant's Name/Relationship (Type, Print)

Allen L. Rausch / son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

same as # 10 above

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Metropolitan Crematory

Date

12-24-98

20c. Location - City or Town, State

Alexandria, VA

21. Signature of Funeral Service Licensee

William R. Jones

22. Name and Address of Facility

Rausch Funeral Home, P.A., Owings, MD 20736

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.

Immediate Cause (Final  
disease or condition  
resulting in death)

a. *pneumonia*  
Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

15 days

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b.   
Due to (or as a consequence of):

c.   
Due to (or as a consequence of):

d.   
Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*dementia*  
*recent myocardial infarction*

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy  
performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings  
available prior to  
completion of cause  
of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical  
examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☒ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 8 ☐ Could not be determined

28a. Date of Injury  
(Month, Day, Year)

28b. Time of  
Injury

28c. Injury at  
Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)

29a. Certifier  
(Check only  
one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Rodney A. Wenrich, MD

29c. License number

D15384

29d. Date signed (Month, Day, Year)

12/20/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RODNEY A. WENRICH

100 POWER ST.

SALISBURY MD

21804

31. Date filed (Month, Day, Year)

DEC 28 1998

32. Registrar's Signature

Beverly B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41042

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

RUDOLF REICHEL

2. Date of Death

Month Day Year  
December 25, 1998 9:30am

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

4180 Dunn Road

4b. City, Town, or Location of Death

Huntingtown

4c. County of Death

Calvert

5. Social Security Number

219 34 9816

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

86 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
June 12, 1912

9. Birthplace (State or Foreign Country)

Czechoslovakia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Calvert

10c. City, Town or Location

Huntingtown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4180 Dunn Road

10f. Zip Code

20639

10g. Citizen of What Country?

Germany

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Farmer

16b. Kind of Business/Industry

Agriculture

17. Father's Name (First, Middle, Last)

August Reichel

18. Mother's Name (First, Middle, Maiden Surname)

Hedwig Benischke

19a. Informant's Name/Relationship (Type, Print)

G. Marianne Terrell

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 1132, Prince Frederick, MD 20678

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Southern Memorial Gardens 12/28/98 Dunkirk, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Charles F. Bell

22. Name and Address of Facility

Rausch Funeral Home, P.A.  
8325 Mt. Harmony Lane, P.O. Box 100, Owings, MD 20678

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Ischemic Myocardopathy

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Arteriosclerotic Cardiovascular Disease Years

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Acute/chronic Congestive Heart Failure

Pneumonia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Gerald P. Sterner MD

29c. License number

D 17245

29d. Date signed (Month, Day, Year)

December 26, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gerald P. Sterner, M.D., P.O. Box 929, 19 Chesapeake Beach Rd. E., Owings, MD, 20736

31. Date filed (Month, Day, Year)

DEC 28 1998

32. Registrar's Signature

Beverly B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



98-7603-009

JAMES

SIMMS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ITEMS: #23 PART I, 27, 28A-F PER MED

Certificate of Death

Reg. No.

98 41043

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) James Simms				2. Date of Death Month Day Year DECEMBER 27, 1998		3. Time of Death 11:55A.M.		
	4a. Facility Name (If not institution, give street and number) 7035 KENT ROAD				4b. City, Town, or Location of Death SUNDERLAND		4c. County of Death CALVERT		
Funeral Director	5. Social Security Number 212-56-5627		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 47 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) March 8, 1951	9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State Maryland		10b. County Calvert		10c. City, Town or Location Sunderland		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 7035 Kent Road				10f. Zip Code 20689		10g. Citizen of What Country? USA		
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Welder		16b. Kind of Business/Industry Welding Company				
	17. Father's Name (First, Middle, Last) William Simms				18. Mother's Name (First, Middle, Maiden Surname) Ramona Green				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Stacey Smith/Sister				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7035 Kent Road Sunderland, MD 20689				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Church of God Chr. Cem.		Date 1/2/99		20c. Location - City or Town, State Huntingtown, MD		
	21. Signature of Funeral Service Licensee Bladyse A. Sewell				22. Name and Address of Facility Sewell Funeral Home 1451 Dares Beach Rd. Prince Frederick, MD 20678				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
	Immediate Cause (Final disease or condition resulting in death) a. COCAINE AND NARCOTIC INTOXICATION Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
						24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input checked="" type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) Found: 12-27-98		28b. Time of Injury Found: 11:46		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred UNKNOWN	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) FOUND AT HOME		28f. Location (Street and Number or Rural Route Number, City or Town, State) 7035 KENT RD., SUNERLAND, MD.					
29e. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier J. Pestaner, M.D.				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) DECEMBER 28, 1998			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201									
31. Date filed (Month, Day, Year) DEC 30 1998		32. Registrar's Signature B. Spauld							

Baltimore, Maryland 21215-0020

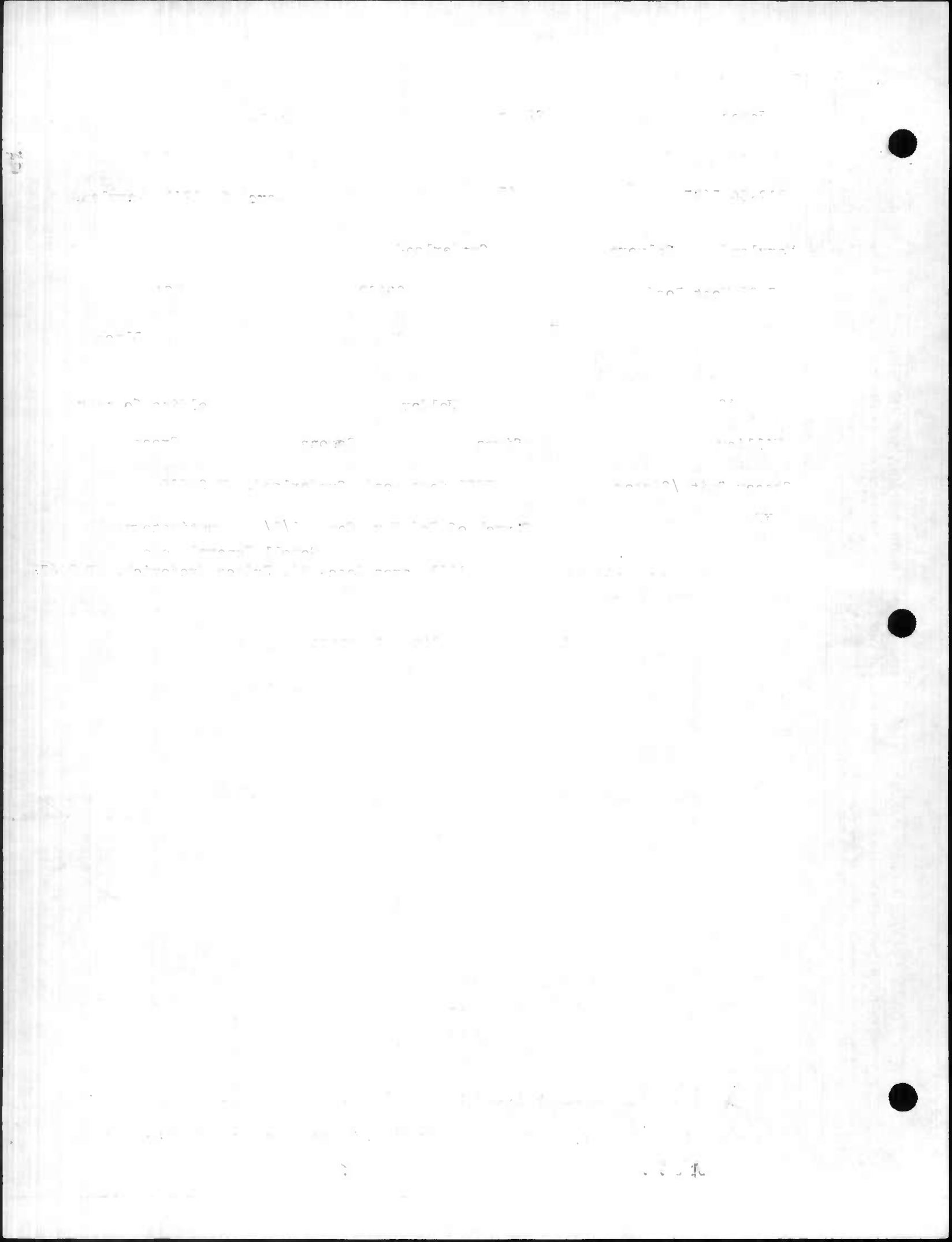
Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41044

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Margaret Elizabeth Smith

2. Date of Death

Dec.

Day

Year

3. Time of Death

7:30AM

4a. Facility Name (If not institution, give street and number)

Bradford Oaks Nursing Home

4b. City, Town, or Location of Death

Clinton

4c. County of Death

Prince George

Funeral  
Director

5. Social Security Number

213-38-3762

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

October 10, 1922

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Lothian

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

190 Boones Drive

10f. Zip Code

20711

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8th

College (1-4or 5+)

N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Waitress

16b. Kind of Business/Industry

Restaurant

17. Father's Name (First, Middle, Last)

James Sanders King

18. Mother's Name (First, Middle, Maiden Surname)

Pearla King

19a. Informant's Name/Relationship (Type, Print)

Katherine Rouser (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

190 Boones Drive Lothian Maryland 20711

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Mary's Catholic Church

Date

Dec. 31, 1998

20c. Location - City or Town, State

Piscataway, Maryland

21. Signature of Funeral Service Director

22. Name and Address of Facility

Lee Funeral Home, Inc.  
6633 Old Alexandria Ferry Rd Clinton, MD 20735

23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Hypertensive Cardiovascular Disease

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia  
Psychosis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D/2906

29d. Date signed (Month, Day, Year)

12/29/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8926 WOODWARD RD, # 602, CLINTON, Md. 20735

Louis Kaufman, M.D.

31. Date filed (Month, Day, Year)

DEC 30 1998

32. Registrar's Signature

Benita S. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

Reg. No.

98 41045

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Ernestine M. Sprague</b>				2. Date of Death Month Day Year <b>Dec 24 1998</b>		3. Time of Death <b>8 30 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>11425 Mill Bridge Road</b>				4b. City, Town, or Location of Death <b>Lusby</b>		4c. County of Death <b>Calvert</b>		
Funeral Director	5. Social Security Number <b>553 54 4878</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>61</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>March 21 1937</b>	9. Birthplace (State or Foreign Country) <b>Germany</b>	
	10a. State <b>Maryland</b>		10b. County <b>Calvert</b>		10c. City, Town or Location <b>Lusby</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number <b>11425 Mill Bridge Road</b>		10f. Zip Code <b>20657</b>		10g. Citizen of What Country? <b>United States</b>				
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>clerk</b>		16b. Kind of Business/Industry <b>Liquor Store</b>				
	17. Father's Name (First, Middle, Last) <b>Alfonz Kopp</b>				18. Mother's Name (First, Middle, Maiden Summa) <b>Bertha Huber</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>Victor Sprague - husband</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>11425 Mill Bridge Rd. Lusby MD 20657</b>				
Physician /Medical Examiner	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metropolitan Funeral Service</b>		20c. Location - City or Town, State <b>Dec 24 1998 Alexandria Virginia</b>		21. Signature of Funeral Service Licensee 		
	22. Name and Address of Facility <b>Rausch Funeral Home PA 4405 Broomes Is. Rd. Port Republic MD 2067</b>								
Medical Certification: To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <u>lung cancer</u> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last { b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>maxillary cancer</u>								
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>D 43306</b>		29d. Date signed (Month, Day, Year) <b>Dec 24 1998</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Sylvia Batong, M.D. 11845 H.G. Trueman Rd. Lusby MD 20657</b>	
31. Date filed (Month, Day, Year) <b>DEC 28 1998</b>		32. Registrar's Signature 							



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41046

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>CARL L. TILEY</b>				2. Date of Death Month <b>Dec</b> Day <b>22</b> Year <b>1998</b>		3. Time of Death <b>1:00PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>6309 Goldenrod Court</b>				4b. City, Town, or Location of Death <b>Upper Marlboro</b>		4c. County of Death <b>Prince George's</b>	
Funeral Director	5. Social Security Number <b>185 24-2400</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>67</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Feb 8, 1931</b>	
	9. Birthplace (State or Foreign Country) <b>Reading, PA</b>		10a. State <b>MD</b>		10b. County <b>P.G.</b>		10c. City, Town or Location <b>Upper Marlboro</b>	
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>6309 Goldenrod Court</b>		10f. Zip Code <b>20772</b>		
10g. Citizen of What Country? <b>United States</b>		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1948</b> <b>1951</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Computer Programmer</b>		16b. Kind of Business/Industry <b>Federal Government</b>		
17. Father's Name (First, Middle, Last) <b>Jefferson Tiley</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Emma Wenger</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Barbara Tiley (WIFE)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6309 Goldenrod Court, Upper Marlboro, MD 20772</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Lee Crematory</b>		20c. Location - City or Town, State <b>Clinton, Maryland</b>		20d. Date <b>December 23, 1998</b>		
21. Signature of Informant or Licensee 				22. Name and Address of Facility <b>Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Cardiomyopathy</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>b. {</b> <b>c. {</b> <b>d. {</b>								
23b. Approximate Interval Between Onset and Death <b>2 years</b>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Congestive Heart Failure</b> <b>Diabetes</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how Injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Sam Tellawi</b>		29c. License number <b>D34274</b>		29d. Date signed (Month, Day, Year) <b>12-23-98</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Sam Tellawi, M.D. 7700 Old Branch Ave, B-102, Clinton, Maryland 20735</b>								
31. Date filed (Month, Day, Year) <b>DEC 30 1998</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

8+1





ADH  
98-7363-033  
UNKNOWN 98-280  
ANTHONY KEITH WILLIAMS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.  
State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

98 41047

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Anthony Keith Williams</b>				2. Date of Death Month Day Year <b>DECEMBER 15, 1998</b>		3. Time of Death <b>0027 AM</b>						
	4a. Facility Name (If not institution, give street and number) <b>PRINCE GEORGES HOSPITAL CENTER</b>				4b. City, Town, or Location of Death <b>CHEVERLY</b>		4c. County of Death <b>PRINCE GEORGES</b>						
Funeral Director	5. Social Security Number <b>577-96-7651</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>31</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Aug 17 1967</b>						
	Usual Residence of Decedent						9. Birthplace (State or Foreign Country) <b>North Carolina</b>						
10a. State <b>D.C.</b>		10b. County		10c. City, Town or Location <b>Washington</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number <b>1425 First Street, S.W.</b>				10f. Zip Code <b>20024</b>		10g. Citizen of What Country? <b>USA</b>							
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>						
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9th</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Unemployed</b>			16b. Kind of Business/Industry <b>NA</b>						
17. Father's Name (First, Middle, Last) <b>Bennie L. Williams</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Annette M. Jackson</b>									
19a. Informant's Name/Relationship (Type, Print) <b>Annette M Jackson (Mother)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1425 First St. SW Wash, D.C. 20024</b>									
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Forest Hills</b>		Date <b>12/26/98</b>		20c. Location - City or Town, State <b>Clinton, MD</b>							
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Austin Royster Funeral Home</b> <b>3821 14th St. NW Wash, D.C. 20011</b>									
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Multiple Injuries</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>								Approximate Interval Between Onset and Death					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> CHDOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)											
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) <b>12/14/98</b>		28b. Time of Injury Found <b>2330</b> M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>Driver of motor vehicle collides with another vehicle</b>					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>Street; Rt 295 + Western Ave; Prince Georges Co, Md.</b>								28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								29b. Signature and title of certifier <b>J. Pestaner, M.D.</b>		29c. License number <b>OCME</b>		29d. Date signed (Month, Day, Year) <b>DECEMBER 15, 1998</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201</b>													
31. Date filed (Month, Day, Year) <b>JAN 8 1999</b>		32. Registrar's Signature 											

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director  
To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

38 41048

Reese P. Wyatt

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "nature", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

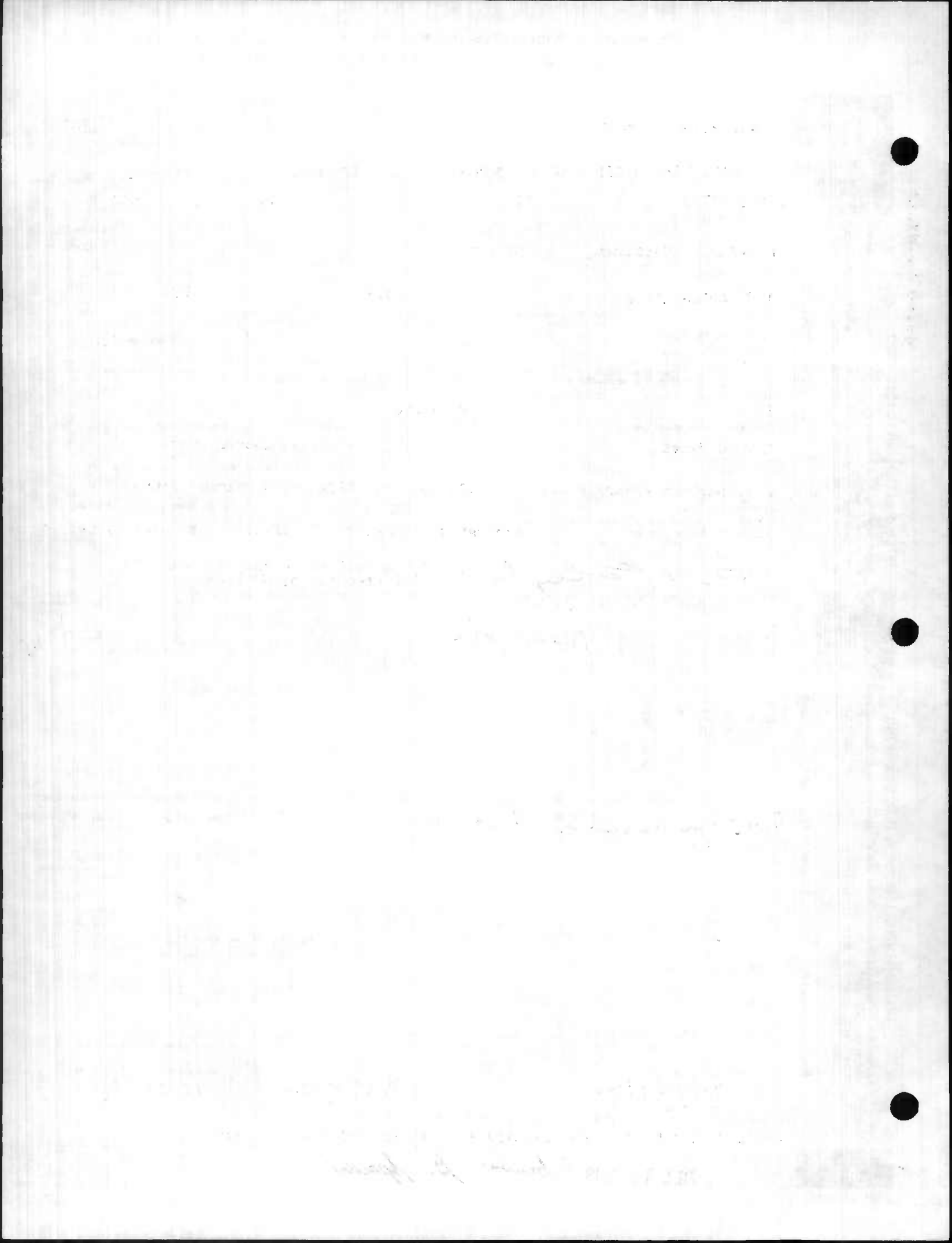
Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Reese Palmer Wyatt</b>						2. Date of Death Month <b>DEC</b> Day <b>27</b> Year <b>1998</b>			3. Time of Death <b>2305</b>	
4a. Facility Name (If not institution, give street and number) <b>MEMORIAL HOSPITAL @ EASTON</b>						4b. City, Town, or Location of Death <b>EASTON</b>			4c. County of Death <b>TALBOT</b>	
5. Social Security Number <b>218-30-1768</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>64</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Aug 27 1934</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		
Usual Residence of Decedent										
10a. State <b>Maryland</b>		10b. County <b>Caroline</b>		10c. City, Town or Location <b>Denton</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>420 Colonial Drive</b>				10f. Zip Code <b>21629</b>		10g. Citizen of What Country? <b>USA</b>				
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11 yrs</b> College (1-4 or 5+) <b></b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>disabled</b>			16b. Kind of Business/Industry <b>N/A</b>			
17. Father's Name (First, Middle, Last) <b>Elwood Wyatt</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Mattie Hubbard Wyatt</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Barbara Evans/ sister</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P.O. Box 743 Ridgely, Maryland 21660</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Greensboro Cemetery</b>		Date <b>12/29</b>		20c. Location - City or Town, State <b>Greensboro, Maryland</b>		
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility <b>Fleegle &amp; Helfenbein Funeral Home, PA Box 160 Greensboro, MD 21639</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Pneumonia</b> Due to (or as a consequence of):  Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Endstage muscular dystrophy</b> Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):						Approximate Interval Between Onset and Death <b>4 days</b>				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Endstage muscular dystrophy</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 				29c. License number <b>D37887</b>		29d. Date signed (Month, Day, Year) <b>12/29/98</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>David H. Smith, MD 509 Idlewild Ave. Easton, Maryland 21601</b>										
31. Date filed (Month, Day, Year) <b>DEC 30 1998</b>		32. Registrar's Signature 								

State  
Registrar



State of Maryland / Department of Health and Mental Hygiene

## Reg. No.

ORIGINAL

**Division of Vital Records, P.O. Box 68760,**

Physician  
/Medical  
Examiner

The law requires that the death certificate be executed within 24 hours after death.

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

te  
ar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 41050

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Bennett Gantt</b>		2. Date of Death Month Day Year <b>December 10, 1998</b>		3. Time of Death <b>10:00 P.M.</b>
	4a. Facility Name (If not institution, give street and number) <b>413 E. Lafayette Avenue</b>		4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>
Funeral Director	5. Social Security Number <b>213-78-4045</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>35</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>03-24-63</b>	9. Birthplace (State or Foreign Country) <b>MD</b>
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State <b>MD</b>	10b. County <b>NA</b>	10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number <b>328 E. LaFayette Avenue</b>		10f. Zip Code <b>21202</b>		10g. Citizen of What Country? <b>USA</b>
To Be Completed by Physician/Medical Examiner	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11th Grade</b> College (1-4 or 5+) <b>NA</b>		
To Be Completed by Physician/Medical Examiner	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Laborer</b>		16b. Kind of Business/Industry <b>various trades</b>		
	17. Father's Name (First, Middle, Last) <b>Albert Johnson</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Lillian Moore</b>		
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Lillian Gantt</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>21202</b> <b>328 E. LaFayette Avenue Baltimore, MD.</b>		
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Greenmount Cemetery</b>		20c. Location - City or Town, State <b>01-11-99 Baltimore, MD</b>
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Baltimore, Maryland 21202</b> <b>WM.C.March FH 1101 E. North Avenue</b>		
	23a. Part I. Enter the disease, or condition, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Smoke Inhalation and Thermal Injury</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>				
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Alcohol and cocaine use</b>				
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
	24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>at scene</b>		
	27. Manner of Death <input type="checkbox"/> Natural <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <b>12-10-98</b>		
To Be Completed by Physician/Medical Examiner	28b. Time of Injury <b>Found.</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>Garage fire</b>
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>garage</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>rear of 413 E. Lafayette Ave., Baltimore</b>		
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. City, MD <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
	29b. Signature and title of certifier 		29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>December 11, 1998</b>
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>111 Penn Street, Baltimore, Maryland 21201</b>				
	31. Date filed (Month, Day, Year) <b>JAN 11 1999</b>		32. Registrar's Signature 		

ORIGINAL





98-7642-510

KEITH A. LEVERETTE  
ASP

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Items: 23 part 1, 27, 28a-f per ME0 1/13/99 reg

Certificate of Death

Reg. No.

98 41051

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last) <b>KEITH A. LEVERETT</b>		2. Date of Death Month <b>DECEMBER</b> Day <b>30</b> Year <b>1998</b>		3. Time of Death <b>2:10 A</b>	
4a. Facility Name (If not institution, give street and number) <b>GOOD SAMARITAN HOSPITAL</b>			4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>NONE</b>
5. Social Security Number <b>217-88-6893</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>35</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>JAN. 23 1963</b>	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>
Usual Residence of Decedent					
10a. State <b>MARYLAND</b>		10b. County <b>PRINCE GEORGE</b>		10c. City, Town or Location <b>LAUREL</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number <b>8607 HARTWOOD PLACE</b>			10f. Zip Code <b>20724</b>		10g. Citizen of What Country? <b>US</b>
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>1 yr.</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>MANAGER</b>		16b. Kind of Business/Industry <b>RUSSELL BMW</b>
17. Father's Name (First, Middle, Last) <b>ALPHONSO LEVERETT</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>CAROLYN WATTS</b>		
19a. Informant's Name/Relationship (Type, Print) <b>MICHELLE LEVERETT (WIFE)</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8607 HARTWOOD PLACE LAUREL, MD. 20724</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>ANNAPOLIS MEM. GARDENS</b>		20c. Location - City or Town, State <b>1/5/99 ANNAPOLIS, MD.</b>	
21. Signature of Funeral Service Licensee <i>Larry G. Reese</i>			22. Name and Address of Facility <b>WM. REESE &amp; SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  a. <b>Cocaine induced-excited delirium</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>found 12/30/98</b>		28b. Time of Injury <b>Unk.</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>Unknown</b>			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>Unknown</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>Unknown</b>			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <i>Dennis J. Chute, MD</i>			29c. License number <b>O.C.M.E</b>		29d. Date signed (Month, Day, Year) <b>DECEMBER 30, 1998</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dennis J. Chute, MD 111 Penn Street, Baltimore, Maryland 21201</b>					
31. Date filed (Month, Day, Year) <b>JAN 11 1999</b>		32. Registrar's Signature <i>B. Sparks</i>			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41052

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>Joseph McFadden</b>					2. Date of Death Month <b>12</b> - Day <b>31</b> - Year <b>98</b>		3. Time of Death <b>2:30 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>CATON MANOR GENESIS ELDER CARE</b>					4b. City, Town, or Location of Death <b>BALTIMORE CITY</b>		4c. County of Death <b>Baltimore City</b>	
<b>Funeral Director</b>	5. Social Security Number <b>216-09-9933</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>85</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Oct. 14, 1913</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent								
10a. State <b>Maryland</b>		10b. County <b>Baltimore City</b>		10c. City, Town or Location <b>Baltimore</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>3330 Wilkens Avenue</b>				10f. Zip Code <b>21229</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WWII</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify:	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4or 5+) <b>0</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Machinist</b>			16b. Kind of Business/Industry <b>Machine Shop</b>		
17. Father's Name (First, Middle, Last) <b>John P. McFadden</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Kate Kelleher</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Unknown</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Unknown</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <b>in state</b>			20b. Place of Disposition (Name of cemetery, crematory or other place)		Data		20c. Location - City or Town, State		
21. Signature of Funeral Service Licensee <b>Ronald S. Wade, Director</b>					22. Name and Address of Facility <b>State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) <b>a. Congestive Heart Failure</b>									<b>3 Days</b>
Due to (or as a consequence of): <b>b. Chronic Atrial flutter</b>									<b>1 Year</b>
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>c. Coronary artery Disease</b>									<b>3 Years</b>
Due to (or as a consequence of): <b>d.</b>									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Basal Cell Carcinoma of face</b>							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
							24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier <b>W. Lymae M. Attending Doctor</b>			29c. License number <b>D21684</b>		29d. Date signed (Month, Day, Year) <b>12-31-98</b>	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>C. V. CYRIAC M.D. 8109 RITCHIE HWY, PASADENA, MD 21129</b>									
31. Date filed (Month, Day, Year) <b>JAN 11 1999</b>			32. Registrar's Signature <b>B. Sparks</b>						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98-7230-51053

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) William Richardson				2. Date of Death Month Day Year DECEMBER 10, 1998				3. Time of Death 0752 AM						
	4a. Facility Name (If not institution, give street and number) 1403 ARGYLE AVENUE				4b. City, Town, or Location of Death BALTIMORE				4c. County of Death N/A						
Funeral Director	5. Social Security Number unknown		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 50 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) August 9, 1948		9. Birthplace (State or Foreign Country) unknown		
	Usual Residence of Decedent														
10a. State MD		10b. County N/A		10c. City, Town or Location Baltimore City						10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					
10e. Street and Number 1403 Argyle Avenue						10f. Zip Code 21217				10g. Citizen of What Country? USA					
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: unknown		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: Black					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) unknown unknown						16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unknown				16b. Kind of Business/Industry unknown					
17. Father's Name (First, Middle, Last) unknown						18. Mother's Name (First, Middle, Maiden Surname) unknown									
19a. Informant's Name/Relationship (Type, Print) Officer King						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 601 E. Fayette Street, Balto., MD 21202									
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) in state				20b. Place of Disposition (Name of cemetery, crematory or other place)				Date		20c. Location - City or Town, State					
21. Signature of Funeral Service Licensee Ronald S. Wade, Director 						22. Name and Address of Facility State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201									
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. INTRACEREBRAL HEMORRHAGE Due to (or as a consequence of): b. COCAINE ABUSE Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last														Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. NARCOTIC INTOXICATION															
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown															
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No															
24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No															
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input checked="" type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year) Found: 12/10/98		28b. Time of Injury 7:30AM		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred Unknown					
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 				29c. License number O.C.M.E.				29d. Date signed (Month, Day, Year) DECEMBER 10, 1998			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201															
31. Date filed (Month, Day, Year) JAN 11 1999				32. Registrar's Signature 											

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 41054

Item:29c per M.D G-767 1/11/99 reb

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

HATTIE

SOLOMON

2. Date of Death

Month  
DECDay  
31Year  
98

3. Time of Death

9:00a

4a. Facility Name (If not institution, give street and number)

University of Maryland Medical Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

250-54-2214

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

68

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

1-19-30

9. Birthplace (State or Foreign Country)

S.C.

Usual Residence of Decedent

10a. State

MD.

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4637 MANORDENE RD.

10f. Zip Code

21229

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

-11-

College (1-4 or 5+)

-0-

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

DOMESTIC

17. Father's Name (First, Middle, Last)

JAKE CARTER

18. Mother's Name (First, Middle, Maiden Surname)

JULIE WILSON

19a. Informant's Name/Relationship (Type, Print)

MARY PITTS (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4637 MANORDENE RD. BALTIMORE, MD 21229

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GARRISON FOREST VET. CEM. 1-7-99 OWINGS MILLS, MD

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

PHILLIPS FUNERAL HOME, P.A.

1721-27 N. MONROE ST. BALTIMORE, MD 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. cerebral herniation

Due to (or as a consequence of):

b. subarachnoid hemorrhage

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Katrina Murphy MD RESIDENT

29c. License number

P-11466

29d. Date signed (Month, Day, Year)

DEC 31, 1998

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

KATRINA MURPHY, MD  
22 S. GREENE ST. STE: 125D BALTIMORE, MARYLAND 21201

31. Date filed (Month, Day, Year)

JAN 11 1999

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41055

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JAMES C. SHAW

2. Date of Death

Month  
12Day  
25Year  
98

3. Time of Death

19:02

4a. Facility Name (If not institution, give street and number)

ANNE ARUNDEL HOSPITAL

4b. City, Town, or Location of Death

ANNAPOLIS

4c. County of Death

ANNE ARUNDEL

Funeral  
Director

5. Social Security Number

214-20-4677

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

74 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

12-9-24

9. Birthplace (State or Foreign Country)

PENNA.

Usual Residence of Decedent

10a. State

MD

10b. County

ANNE ARUNDEL

10c. City, Town or Location

ANNAPOLIS

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

894 MARENGO STREET

10f. Zip Code

21401

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates: W.W. II13. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: BLACK

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
-12-College (1-4 or 5+)  
-0-16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

DOCKETT CLERK

16b. Kind of Business/Industry

PATTEN OFFICE

17. Father's Name (First, Middle, Last)

JAMES C. SHAW SR.

18. Mother's Name (First, Middle, Maiden Surname)

ELLA MANN

19a. Informant's Name/Relationship (Type, Print)

THELMA SHAW (WIFE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

894 MARENGO ST. ANNAPOLIS, MD 21401

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

METRO CREMATORY

Date

12-30-98

20c. Location - City or Town, State

BALTIMORE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

WM. REESE &amp; SONS MORTUARY, P.A.

821 WEST ST. ANNAPOLIS MD 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final  
disease or condition  
resulting in death)e. *Acute Cardiac Ischemia*  
Due to (or as a consequence of):Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb.   
Due to (or as a consequence of):c.   
Due to (or as a consequence of):d.   
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death*few hrs*

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*Concussion of Skull*

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D87541

29d. Date signed (Month, Day, Year)

Jan, 7, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

GEETHA RAZA, 4367 Hollins Ferry Rd Baltimore MD-21228

31. Date filed (Month, Day, Year)

JAN 11 1999

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

08 41056

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Felix J. Alliegro</b>				2. Date of Death Month Day Year <b>Dec 12, 1998</b>				3. Time of Death <b>10:30AM</b>				
	4a. Facility Name (If not institution, give street and number) <b>Malcolm Grow Medical Center</b>				4b. City, Town, or Location of Death <b>Camp Spring</b>				4c. County of Death <b>Prince George</b>				
Funeral Director	5. Social Security Number <b>042-18-5431</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>85</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>February 24, 1913</b>		9. Birthplace (State or Foreign Country) <b>New York</b>				
	Usual Residence of Decedent												
To Be Completed by Funeral Director	10a. State <b>Md.</b>		10b. County <b>Pr. Geo.</b>		10c. City, Town or Location <b>Morningside</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
	10a. Street and Number <b>6708 Marianne Dr.</b>				10f. Zip Code <b>20746</b>		10g. Citizen of What Country? <b>U.S.A.</b>						
To Be Completed by Physician/Medical Examiner	11. Marital Status <input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>N/A</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Engineer - Building</b>				16b. Kind of Business/Industry <b>Dept. of Treasury</b>				
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>Vincent Alliegro</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Carmen Alliegro</b>								
	19a. Informant's Name/Relationship (Type, Print) <b>Beulah Alliegro (Wife)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6708 Marianne Drive Morningside, MD 20746</b>								
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Dec. 16, 1998</b> <b>Maryland State Veterans Cem.</b>				20c. Location - City or Town, State <b>Cheltenham, Maryland</b>				
	21. Signature of Funeral Service Licensee				22. Name and Address of Facility <b>Lee Funeral Home, Inc.</b> <b>6633 Old Alexandria Ferry Road Clinton, MD 20735</b>								
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>CARDIAC ARREST DUE TO ARRHYTHMIA</b> Due to (or as a consequence of): <b>CARDIAC ARRHYTHMIA</b> Due to (or as a consequence of): <b>CORONARY ARTERY DISEASE</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  <b>Hypertension, Diabetes Mellitus,</b>										Approximate Interval Between Onset and Death <b>minutes</b> <b>minute</b> <b>years</b>		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hypertension, Diabetes Mellitus,</b>										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <b>Edward T. Cullen</b>				29c. License number <b>D-26607</b>		29d. Date signed (Month, Day, Year) <b>12/14/98.</b>		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Edward T. Cullen M.D. 4333 Old Branch Avenue Marlow Heights, MD 20748</b>										31. Date filed (Month, Day, Year) <b>DEC 17 1998</b>		32. Registrar's Signature <b>B. Sparks</b>

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41057

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CANDIDA JAMITO AGUILAR

2. Date of Death

Month Day Year  
DECEMBER 16, 1998

3. Time of Death

9:20PM

4a. Facility Name (If not institution, give street and number)

3317 RANDALL ROAD

4b. City, Town, or Location of Death

SUITLAND

4c. County of Death

PRINCE GEORGE'S

Funeral  
Director

5. Social Security Number

577-86-3286

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
SEPT. 22, 1917

9. Birthplace (State or Foreign Country)

PHILIPPINES

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

PRINCE GEORGE'S

10c. City, Town or Location

SUITLAND

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

3317 RANDALL RD.

10f. Zip Code

20746

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: FILIPINO

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

HOUSEKEEPING

16b. Kind of Business/Industry

HOTEL INDUSTRY-PVT.

17. Father's Name (First, Middle, Last)

UNKNOWN

18. Mother's Name (First, Middle, Maiden Surname)

UNKNOWN

19a. Informant's Name/Relationship (Type, Print)

EARNESTINE DAVIS / GRANDDAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2601 NAYLOR RD. SE #2 WASHINGTON, DC 20020

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

WASHINGTON NATIONAL

Date

12-22-98

20c. Location - City or Town, State

SUITLAND, MD

21. Signature of Funeral Service Licensee

Juwana K. Brayton

22. Name and Address of Facility

MARSHALL'S FUNERAL HOME OF MD  
4308 SUITLAND RD. SUITLAND, MARYLAND 2074623a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

Cancer of Tongue with SIP Radical Neck Dissection

a. Due to (or as a consequence of):

Thyroidoma

b. Due to (or as a consequence of):

Rectal Bleeding due to Polyp

c. Due to (or as a consequence of):

Hepatic Dystrophy

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury28c. Injury et  
Work?1 ☐ Yes 2 ☐ No28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

K. D. Damarco

29c. License number

DE25640

29d. Date signed (Month, Day, Year)

DEC. 22, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. KHOSROW DAVACHI 1328 SOUTHERN AVE. #202 WASHINGTON, DC

31. Date filed (Month, Day, Year)

DEC 21 1998

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
900-222-2222.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

DEC 8 1950



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41058

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Martin Clifford Bussard

2. Date of Death  
Month Day Year  
December 27 1998

3. Time of Death  
11:20am

4a. Facility Name (If not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

Funeral  
Director

5. Social Security Number  
216-14-5270

6. Sex  
1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)  
79 Yrs.

8. Date of Birth (Month, Day, Year)  
Sept. 18, 1919

9. Birthplace (State or Foreign Country)  
Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Sharpsburg

10d. Inside City Limits  
1 ☒ Yes 2 ☐ No

10e. Street and Number

17418 Shepherdstown Pike

10f. Zip Code

21782

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.  
Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Mail Carrier

16b. Kind of Business/Industry

Postal Service

17. Father's Name (First, Middle, Last)

Martin Luther Bussard

18. Mother's Name (First, Middle, Maiden Surname)

Minnie Golden Pearl Baker

19a. Informant's Name/Relationship (Type, Print)

Audrey M. Bussard (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

17418 Shepherdstown Pike Sharpsburg Maryland 21782

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Cedar Lawn Memorial Park

Date

12-30-98 Hagerstown, Maryland

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Osborne Funeral Home 425 S. Conococheague St.  
Williamsport, Maryland 21795

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.

Immediate Cause (Final  
disease or condition  
resulting in death)

a. Community Acquired Pneumonia  
Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

3 weeks

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus, Type I

Acute and Chronic Renal failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy  
performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings  
available prior to  
completion of cause  
of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined

28a. Date of Injury  
(Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)

29a. Certifier  
(Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Robert Brull MD. Coverage for Personal Physician

29c. License number

DO4359

29d. Date signed (Month, Day, Year)

December 27 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert Brull 1459 Potomac Ave Hagerstown, Md 21742

State  
Registrar

31. Date filed (Month, Day, Year)

DEC 28 1998

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41059

Physician  
/Medical  
Examiner

Funeral  
Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Eunice B. Belote</b>				2. Date of Death Month <b>12</b> Day <b>22</b> Year <b>98</b>		3. Time of Death <b>0900</b>	
4a. Facility Name (If not institution, give street and number) <b>Home 800 Laurel ST</b>				4b. City, Town, or Location of Death <b>Pocomoke City</b>		4c. County of Death <b>Worcester</b>	
5. Social Security Number <b>218-24-6168</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>67</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>12 23 30</b>	
9. Birthplace (State or Foreign Country) <b>VIRGINIA</b>		10a. State <b>md</b>		10b. County <b>worcester</b>		10c. City, Town or Location <b>Pocomoke City</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>800 Laurel ST</b>		10f. Zip Code <b>21851</b>		10g. Citizen of What Country? <b>United States</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> Collega (14 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Laborer</b>		16b. Kind of Business/Industry <b>poultry</b>		17. Father's Name (First, Middle, Last) <b>William Broadwater</b>	
18. Mother's Name (First, Middle, Maiden Surname) <b>margie marshall</b>		19a. Informant's Name/Relationship (Type, Print) <b>Joyce Patterson daughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3712 Sheephouse Rd Pocomoke City, md</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	
20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Wardtown Cem.</b>		20c. Location - City or Town, State <b>1/2/99 Pocomoke City, md</b>		21. Signature of Funeral Service Licensee <b>Seith E. Wharton</b>		22. Name and Address of Facility <b>WHARTON FUNERAL HOME 22171 Wharton Rd Accomack, VA 23301</b>	
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>net Small Cell Lung Ca</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>12/23/98</b>	
28b. Time of Injury <b>M</b>		28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Dr. Joseph A. Grasso</b>		29c. License number <b>20507</b>		29d. Date signed (Month, Day, Year) <b>12/30/98</b>	
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) <b>Dr. Joseph A. Grasso, 145 E. Carroll St, Salisbury MD 21801</b>		31. Date filed (Month, Day, Year) <b>DEC 30 1998</b>		32. Registrar's Signature <b>B. Sparks</b>			

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41060

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

NORMAN

BAILEY

2. Date of Death

December 27, 1998

3. Time of Death

11:15 AM

4a. Facility Name (If not institution, give street and number)

Wicomico Nursing Home

4b. City, Town, or Location of Death

Salisbury, MD

4c. County of Death

Wicomico

5. Social Security Number

186-09-7693

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

90

8. Date of Birth

8/22/1908

9. Birthplace (State or Foreign Country)

Penn.

Usual Residence of Decedent

10a. State

Md.

10b. County

Wicomico

10c. City, Town or Location

Tyaskin

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

P.O. Box 105

10f. Zip Code

21865

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No WW 2  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
11

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Ret. Army Serviceman

16b. Kind of Business/Industry

W.W. 2

17. Father's Name (First, Middle, Last)

Nathon Bailey

18. Mother's Name (First, Middle, Maiden Surname)

Sylvia Katz

19a. Informant's Name/Relationship (Type, Print)

Catherine Bailey, Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 105, Tyaskin, Maryland 21865

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parsons Cemetery

Date

1/2/99 Tyaskin, Md.

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

MOO-417

22. Name and Address of Facility

Messick Funeral Home, P.O. Box 61  
Bivalve, Maryland 21814

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Arteriosclerotic Cardiovascular Disease

Approximate Interval Between Onset and Death

4 yrs

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus Type II; CVAHypothyroidism; AnemiaSeizure Disorder

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gregoria M. Belloso, MD - 5302 Chinaberry Dr., Salis., MD 21801

31. Date filed (Month, Day, Year)

DEC 28 1998

32. Registrar's Signature

Denise A. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

IVAT 5

NORMAN BAILEY



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41061

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) <b>HERMAN J. BAKER</b>				2. Date of Death Month Day Year <b>December 24 1998</b>		3. Time of Death <b>1100</b>	
4a. Facility Name (If not institution, give street and number) <b>PENINSULA REGIONAL MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>SALISBURY</b>		4c. County of Death <b>WICOMICO</b>	
5. Social Security Number <b>222-14-3501</b>		6. Sex <b>1 M 2 F</b>	7. Age (In yrs. last birthday) <b>77 Yrs.</b>	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>MAR. 19, 1921</b>	
9. Birthplace (State or Foreign Country) <b>MARYLAND</b>							
10a. State <b>MARYLAND</b>		10b. County <b>WORCESTER</b>		10c. City, Town or Location <b>BISHOPVILLE</b>			10d. Inside City Limits <b>1 Yes 2 No</b>
10e. Street and Number <b>10119 BISHOPVILLE ROAD</b>				10f. Zip Code <b>21813</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>1 Yes 2 No</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 Yes 2 No Specify:</b>		14. Race - American Indian, Black, White, etc. <b>Specify: WHITE</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) <b>1</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>BANKER</b>		16b. Kind of Business/Industry <b>BANKING</b>	
17. Father's Name (First, Middle, Last) <b>CARL H. BAKER</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>KATIE DAVIS</b>			
19a. Informant's Name/Relationship (Type, Print) <b>PHYLLIS C. BAKER/WIFE</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10119 BISHOPVILLE ROAD, BISHOPVILLE, MARYLAND 21813</b>			
20a. Method of Disposition <b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>BISHOPVILLE CEMETERY</b>		Date <b>12/29/98</b>		20c. Location - City or Town, State <b>BISHOPVILLE, MARYLAND</b>	
21. Signature of Funeral Service Licensee <i>Charles H. Sparks</i>				22. Name and Address of Facility <b>HASTINGS FUNERAL HOME, SELBYVILLE, DELAWARE 19975</b>			
23a. Part I. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>SEPSIS</b>							
23b. Dtd tobacco use contribute to the cause of death? <b>1 Yes 2 No 3 Probably 4 Unknown</b>							
23c. Was an autopsy performed? <b>1 Yes 2 No</b>							
23d. Were autopsy findings available prior to completion of cause of death? <b>1 Yes 2 No</b>							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>- Abul. Aortic Aneurysm</b> <b>- Bilab. Shic art. Stenosis</b> <b>- Pneumonia - COLD</b>							
25. Was case referred to medical examiner? <b>1 Yes 2 No</b>		26. Place of Death (Check only one) Hospital: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> Other: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b>					
27. Manner of Death <b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined</b>		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <b>1 Yes 2 No</b>	
28d. Describe how Injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <b>1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> <b>2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b>							
29b. Signature and title of certifier <i>Charles H. Sparks</i>				29c. License number <b>53611</b>		29d. Date signed (Month, Day, Year) <b>12/24/98</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>547-G Riverside Dr Salisbury, MD 21801.</b>							
31. Date filed (Month, Day, Year) <b>DEC 28 1998</b>				32. Registrar's Signature <i>Charles H. Sparks</i>			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State  
Registrar





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State of Maryland / Department of Health and Mental Hygiene 98 41062

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>LANA RAY BUNTING</b>				2. Date of Death Month <b>DEC.</b> Day <b>22</b> Year <b>1998</b>		3. Time of Death <b>12:45 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>12102 GODFREY-BUNTING ROAD</b>				4b. City, Town, or Location of Death <b>BISHOPVILLE</b>		4c. County of Death <b>WORCESTER</b>	
Funeral Director	5. Social Security Number <b>218-48-6840</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>49</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>NOV. 23, 1949</b>	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>
	Usual Residence of Decedent							
10a. State <b>MARYLAND</b>		10b. County <b>WORCESTER</b>		10c. City, Town or Location <b>BISHOPVILLE</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>12102 GODFREY-BUNTING ROAD</b>				10f. Zip Code <b>21813</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>REALTOR</b>		16b. Kind of Business/Industry <b>REAL ESTATE</b>		
17. Father's Name (First, Middle, Last) <b>WALTER H. BUNTING</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>EVA N. SAVAGE</b>				
19a. Informant's Name/Relationship (Type, Print) <b>WALTER H. BUNTING/FATHER</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>12102 GODFREY-BUNTING ROAD, BISHOPVILLE, MD 21813</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>SALISBURY CREMATORY</b>		20c. Location - City or Town, State <b>12/23/98 SALISBURY, MARYLAND</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>HASTINGS FUNERAL HOME, SELBYVILLE, DELAWARE 19975</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Metastatic Colon Cancer</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>b. {</b> <b>c. {</b> <b>d. {</b>				Approximate Interval Between Onset and Death <b>2 1/2 years</b>				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
				28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner				29b. Signature and title of certifier  MD				
				29c. License number <b>026278</b>		29d. Date signed (Month, Day, Year) <b>12-22-98</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>David E. Cowell, MD 1455 Cornwall St. Salisbury, MD 21801</b>								
31. Date filed (Month, Day, Year) <b>DEC 23 1998</b>				32. Registrar's Signature 				

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

8

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **98 41063**  
**Certificate of Death** Reg. No.

**Physician  
/Medical  
Examiner**

**Funeral  
Director**

1. Decedent's Name (First, Middle, Last) <b>MASON HERBERT BOBLETT, SR.</b>		2. Date of Death Month <b>DECEMBER</b> Day <b>28</b> Year <b>1998</b>		3. Time of Death <b>09:30AM</b>	
4a. Facility Name (If not institution, give street and number) <b>SOUTHERN MARYLAND HOSPITAL CENTER</b>		4b. City, Town, or Location of Death <b>CLINTON</b>		4c. County of Death <b>PRINCE GEORGES</b>	
5. Social Security Number <b>232-64-4188</b>		8. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>57</b> Yrs.	
6. Usual Residence of Decedent		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
10a. State <b>Maryland</b>		10b. County <b>Charles</b>		10c. City, Town or Location <b>Waldorf</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>2502 Lisa Drive</b>		10f. Zip Code <b>20601</b>	
10g. Citizen of What Country? <b>U.S.A.</b>		8. Date of Birth (Month, Day, Year) <b>Feb. 1, 1941</b>		9. Birthplace (State or Foreign Country) <b>West Virginia</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Service Man</b>		16b. Kind of Business/Industry <b>Washington Gas Co.</b>	
17. Father's Name (First, Middle, Last) <b>Charlie Dillard Boblett</b>		18. Mother's Name (First, Middle, Maiden Summa) <b>Pearl Mae Milsap</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Anita L. Boblett/Wife</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2502 Lisa Drive, Waldorf, Maryland 20601</b>			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>The Hunt Crematory</b>		20c. Location - City or Town, State <b>Jan. 01, 1999 Waldorf, Maryland</b>	
21. Signature of Funeral Service Licensee <b>DAVID A. GOFF</b>		22. Name and Address of Facility <b>The Hunt Funeral Home, Inc. P. O. Box 156, Waldorf, Maryland 20604</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b.</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>		Approximate Interval Between Onset and Death			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. Signature and title of certifier <b>[Signature]</b>		29c. License number <b>D339154</b>		29d. Date signed (Month, Day, Year) <b>DECEMBER 28, 1998</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MARIO F. GOLIE JR MD 3001 HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785</b>					
31. Date filed (Month, Day, Year) <b>DEC 31 1998</b>		32. Registrar's Signature <b>[Signature]</b>			

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician  
/Medical  
Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 41064

Certificate of Death

Reg. No.

4 0/4

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

Funeral Director

1. Decedent's Name (First, Middle, Last) ROMAINE ANGELA MOORE-BOWLES				2. Date of Death Month DECEMBER Day 16 Year 1998		3. Time of Death 6:30 PM	
4a. Facility Name (If not Institution, give street and number) 6000 Sellner Lane				4b. City, Town, or Location of Death Clinton		4c. County of Death Prince Georges	
5. Social Security Number 577-78-5070		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 40 Yrs.		8. Date of Birth (Month, Day, Year) NOV 6 1958	
9. Birthplace (State or Foreign Country) Wash., D.C.		10a. State Maryland		10b. County Prince Georges		10c. City, Town or Location Clinton	
10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 6000 Sellner Lane		10f. Zip Code 20735		10g. Citizen of What Country? United States	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) _____		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary		16b. Kind of Business/Industry U.S. Government			
17. Father's Name (First, Middle, Last) Elridge Randolph Moore, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Kathleen Harris			
19a. Informant's Name/Relationship (Type, Print) Velma Godfrey / Sister				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6000 Sellner Lane, Clinton, Maryland 20735			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Lincoln Memorial Cemetery		20c. Location - City or Town, State Suitland, Maryland		20d. Date 12/22/98	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility M859 ALEXANDER S. POPE FUNERAL HOMES 2617 Pennsylvania Avenue, SE DC 20020					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. End Stage Sarcoidosis Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):				Approximate Interval Between Onset and Death			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number D0044259		29d. Date signed (Month, Day, Year) 12/17/98	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JANET M. JONES, MD 8926 Woodlyard Rd Suite 602 Clinton, Md 20735							
31. Date filed (Month, Day, Year) DEC 23 1998		32. Registrar's Signature 					

77



*[Handwritten signature]*

DEC 2 1930



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State of Maryland / Department of Health and Mental Hygiene 98 41065

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Roswell Runkle Boyer				2. Date of Death Month Day Year December 17, 1998		3. Time of Death 10:35 AM	
	4a. Facility Name (If not institution, give street and number) 44815 Three Coves Road				4b. City, Town, or Location of Death Hollywood		4c. County of Death St. Mary's	
Funeral Director	5. Social Security Number 577-18-7750		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 94 Yrs.		8. Date of Birth (Month, Day, Year) December 31, 1903	
	9. Birthplace (State or Foreign Country) Pennsylvania		10a. State Maryland		10b. County St. Mary's		10c. City, Town or Location Hollywood	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 44815 Three Coves Road		10f. Zip Code 20636		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Training Staff Officer		16b. Kind of Business/Industry U.S. Army			
	17. Father's Name (First, Middle, Last) Ezra Clinton Boyer				18. Mother's Name (First, Middle, Maiden Surname) Elvina M. Runkle			
	19a. Informant's Name/Relationship (Type, Print) Theodore C. Boyer/Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 524, Waldorf, MD 20604			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Arlington National Cemetery		Date 12/28/98		20c. Location - City or Town, State Arlington, Virginia	
	21. Signature of Funeral Service Licensee <i>Richard H. [Signature]</i>				22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, MD 20650			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Atherosclerotic Cardiovascular disease</i> <i>K13</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
							24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) —		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) —				28d. Describe how injury occurred —			
	28f. Location (Street and Number or Rural Route Number, City or Town, State) —							
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
State Registrar	29b. Signature and title of certifier <i>Dr. Boyd</i>				29c. License number 018285		29d. Date signed (Month, Day, Year) 12-17-98	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William D. Boyd, II, MD Leonardtown, Maryland 20650							
31. Date filed (Month, Day, Year) DEC 21 1998								
32. Registrar's Signature <i>B. Sparks</i>								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41066

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Edna Marie Brown</b>				2. Date of Death Month Day Year <b>DECEMBER 22, 1998</b>		3. Time of Death <b>6:55 P.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>Sacred Heart Hospital</b>				4b. City, Town, or Location of Death <b>Cumberland</b>		4c. County of Death <b>Allegany</b>	
Funeral Director	5. Social Security Number <b>212-24-0030</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>80</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>28-Jun-18</b>	
	9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>							
Usual Residence of Decedent								
10a. State <b>Maryland</b>		10b. County <b>Allegany</b>		10c. City, Town or Location <b>Frostburg</b>			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number <b>941 West Finzel Road</b>				10f. Zip Code <b>21532-</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>0</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Homemaker</b>		
17. Father's Name (First, Middle, Last) <b>William Deal</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Baer</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Wanda Coughenour Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>941 West Finzel Road Frostburg Maryland 21532</b>				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Greenville Lutheran Cemetery</b>		20c. Location - City or Town, State <b>24-Dec-98 Pocahontas, Pennsylvania</b>		
21. Signature of Funeral Service Licensee <i>John R. Durst</i>				22. Name and Address of Facility <b>Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
Immediate Cause (Final disease or condition resulting in death)				a. <b>ACUTE MYOCARDIAL INFARCTION</b>				Approximate Interval Between Onset and Death <b>4 days</b>
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				b. <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b>				<b>5 years</b>
				c. Due to (or as a consequence of):				
				d. Due to (or as a consequence of):				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
<b>HYPERTENSION</b>								
<b>DIABETES MELLITUS</b>								
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input type="checkbox"/> Attending Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>Joseph T. Coveria</i> <b>PHYSICIAN</b>				29c. License number <b>D50844</b>		29d. Date signed (Month, Day, Year) <b>DECEMBER 23, 1998</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>JOSE T. COVERIA JR., M.D. 912 SETON DRIVE CUMBERLAND, MD 21502</b>								
31. Date filed (Month, Day, Year) <b>DEC 28 1998</b>				32. Registrar's Signature <i>[Signature]</i>				

Edna Marie Brown

Sacred Heart Hospital

213-24-0030

80

28-Jul-18

Pennsylvania

Allegheny

Cumbehand

Frostburg

Allegheny

Maryland

941 West Finsel Road

21335-

U.S.A.

Wife

8

0

Homebucker

Homebucker

William Deal

Mary Baer

Wanda Coughenour

Daughter

941 West Finsel Road

Frostburg

Maryland

21335-

24-Dec-98 Pocahtonlas, Pennsylvania

Greenville Lutheran Cemetery

Dust Funeral Home, 57 First Ave., Frostburg, MD 21332

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 41067  
Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Elizabeth Helene Bowman

2. Date of Death

Month Day Year  
Dec 17, 1998

3. Time of Death

12:00 p.m.

4a. Facility Name (If not institution, give street and number)

Devlin Manor Nursing Home

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegheny

Funeral  
Director

5. Social Security Number

214-28-6637

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

67 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
May 3, 1931

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10e. State

MD

10b. County

Allegheny

10c. City, Town or Location

Cumberland

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

504 Prince George Street

10f. Zip Code

21502

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.Specify:  
white15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

18e. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Cafeteria Manager

16b. Kind of Business/Industry

School

17. Father's Name (First, Middle, Last)

H. Clifford Spiker

18. Mother's Name (First, Middle, Maiden Surname)

Mary Kay (Davidson)

19a. Informant's Name/Relationship (Type, Print)

Robert E. Bowman-husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

504 Prince George Street; Cumberland, MD 21502

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

St. Mary's Cemetery

Date

12/22

20c. Location - City or Town, State

Cumberland, MD

21. Signature of Funeral Service Licensee

Nicholas J. Scarpelli

22. Name and Address of Facility

Scarpelli Funeral Home, P.A.  
Cumberland, MD 2150223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Pneumonia  
Dua to (or as a consequence of):Approximate  
Interval Between  
Onset and Death

2 days

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb.   
Dua to (or as a consequence of):c.   
Dua to (or as a consequence of):d.   
Dua to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined28a. Date of Injury  
(Month, Day, Year)28b. Time of  
injury28c. Injury of  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

A. J. Bollino MD

29c. License number

D0017565

29d. Date signed (Month, Day, Year)

Dec 22, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A. J. Bollino MD 922 National Hwy L2U212 MD 21502

31. Date filed (Month, Day, Year)

DEC 22 1998

32. Registrar's Signature

A. J. Bollino

State  
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



98 41068

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Maxine Timbrook Barger</b>				2. DATE OF DEATH MONTH DAY YEAR <b>Dec. 20, 1998</b>		3. TIME OF DEATH p m <b>9:55 p</b>	
4. SOCIAL SECURITY NUMBER <b>232-26-3645</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>77</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Dec. 21, 1920</b>	
8. BIRTHPLACE (State or Foreign Country) <b>West Virginia</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Memorial Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Cumberland</b>	
9c. COUNTY OF DEATH <b>Allegany</b>				10a. STATE <b>WV</b>		10b. COUNTY <b>Mineral</b>	
10c. CITY, TOWN OR LOCATION <b>Keyser</b>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>135 Willow Avenue</b>	
10f. ZIP CODE <b>26726</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th.</b> College (1-4 or 5+) <b>Case Worker Social Services State Government</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Case Worker Social Services</b>		16b. KIND OF BUSINESS/INDUSTRY <b>State Government</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Charles L. Timbrook</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Katherine Messick</b>			
19a. INFORMANT'S NAME (Type/Print) <b>John R. Barger (Son)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>116 South Water Street, Keyser, WV 26726</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Queens Point Cemetery 12/23/98</b>		20c. LOCATION — City or Town, State <b>Keyser, WV 26726</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Harold Dean Nopsinger</i>				22. NAME AND ADDRESS OF FACILITY <b>Markwood Funeral Home 111 S. Mineral Street, Keyser, WV 26726</b>			
23. PART I. Enter the diseases, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>EMPHYSEMA</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suiicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE NOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. James M. Ravers</i>				29c. LICENSE NUMBER <b>D18769</b>		29d. DATE SIGNED (Month, Day, Year) <b>12/22/98</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. James M. Ravers, M.D. Memorial Hospital, 400 Memorial Ave., Cumberland, Md 21502</b>							
31. DATE FILED (Month, Day, Year) <b>DEC 23 1998</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41069

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Mary Margaret Burkett</b>				2. Date of Death Month <b>Dec</b> Day <b>16</b> Year <b>1998</b>		3. Time of Death <b>9:05 am</b>	
	4a. Facility Name (If not institution, give street and number) <b>Cumberland Nursing Center</b>				4b. City, Town, or Location of Death <b>Cumberland</b>		4c. County of Death <b>Allegany</b>	
Funeral Director	5. Social Security Number <b>219-56-7538</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>95</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Oct 5, 1903</b>	
	Usual Residence of Decedent		9. Birthplace (State or Foreign Country) <b>PA</b>		10. City, Town or Location <b>Cresaptown</b>		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Funeral Director	10a. State <b>MD</b>		10b. County <b>Allegany</b>		10c. City, Town or Location <b>Cresaptown</b>		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number <b>14700 Oakwood Street</b>				10f. Zip Code <b>21502</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		18b. Kind of Business/Industry <b>Own Home</b>			
	17. Father's Name (First, Middle, Last) <b>Charles Fochtman</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Grace (Layman)</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Paul L. Burkett-son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>13613 Yuma Street Cumberland MD 21502</b>			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>St. Ambrose Cemetery</b>		Date <b>12/19</b>		20c. Location - City or Town, State <b>Cresaptown MD</b>	
	21. Signature of Funeral Service Licensee <b>James F. Scarpelli</b>		22. Name and Address of Facility <b>Scarpelli Funeral Home, P.A. Cumberland MD 21502</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Aspiration Pneumonia</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last { b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Approximate Interval Between Onset and Death <b>1 day</b>							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Diabetes Mellitus</b> <b>cerebrovascular Accident</b>						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Dr. Sunil Gupta</b>		29c. License number <b>D 33280</b>		29d. Date signed (Month, Day, Year) <b>Dec 18, 1998</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Dr. Sunil Gupta 625 Kent Avenue Cumberland MD 21502</b>								
31. Date filed (Month, Day, Year) <b>DEC 21 1998</b>		32. Registrar's Signature <b>[Signature]</b>						

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41070

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Dean Ambrose Bronzonie</b>		2. Date of Death Month Day Year <b>DECEMBER 16, 1998</b>		3. Time of Death <b>2105 PM</b>	
4a. Facility Name (If not institution, give street and number) <b>CALVERT MEMORIAL HOSPITAL</b>		4b. City, Town, or Location of Death <b>PRINCE FREDERICK</b>		4c. County of Death <b>CALVERT</b>	
5. Social Security Number <b>577 50 0160</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>61</b> Yrs.	
8. Date of Birth (Month, Day, Year) <b>April 15, 1937</b>		9. Birthplace (State or Foreign Country) <b>Wash, DC</b>		10. Usual Residence of Decedent	
10a. State <b>MD</b>		10b. County <b>Calvert</b>		10c. City, Town or Location <b>Huntingtown</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>530 Carla Drive</b>		10f. Zip Code <b>20639</b>	
10g. Citizen of What Country? <b>USA</b>		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+) <b>2</b>	
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>meat cutter</b>		16b. Kind of Business/Industry <b>retail - food</b>		17. Father's Name (First, Middle, Last) <b>Dean Ambrose Bronzonie</b>	
18. Mother's Name (First, Middle, Maiden Surname) <b>Mattie Marie Morris</b>		19a. Informant's Name/Relationship (Type, Print) <b>Judith A. Bronzonie/wife</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>same as 10 above</b>	
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metropolitan Crematory</b>		20c. Location - City or Town, State <b>12-19-98 Alexandria, VA</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Rausch Funeral Home, Owings, MD 20736</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Atherosclerotic Cardiovascular Disease</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____	
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <b>INSPECTION</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <b>12-19-98</b>		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 	
29c. License number <b>OCME</b>		29d. Date signed (Month, Day, Year) <b>DECEMBER 17, 1998</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dennis J. Chute, MD 111 Penn Street, Baltimore, Maryland 21201</b>	
31. Date filed (Month, Day, Year) <b>DEC 21 1998</b>		32. Registrar's Signature 		33. State Registrar <b>State Registrar</b>	



98-7593-033

98-300

RUTH BLACKWELL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

MPO 6761 1-20-99 WR.  
Certificate of Death

Reg. No.

98 41071

ITEMS: #23 PART I, II, 27 PER

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Ruth Louise Blackwell</b>				2. Date of Death Month Day Year <b>DECEMBER 26, 1998</b>		3. Time of Death <b>6:25P.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>2601 COLEBROOK PARKWAY</b>				4b. City, Town, or Location of Death <b>TEMPLE HILLS</b>		4c. County of Death <b>PRINCE GEORGES</b>	
Funeral Director	5. Social Security Number <b>578-64-8384</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>51</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>1947 November 17,</b>	
	9. Birthplace (State or Foreign Country) <b>Washington, D.C.</b>		10a. State <b>Maryland</b>		10b. County <b>Prince Georges</b>		10c. City, Town or Location <b>Temple Hills</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number <b>3847 - 26th Avenue</b>		10f. Zip Code <b>20748</b>		10g. Citizen of What Country? <b>United States</b>	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>2 years</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Head Cook</b>		16b. Kind of Business/Industry <b>U.S. Department of Agriculture</b>			
	17. Father's Name (First, Middle, Last) <b>Robert Blackwell, Sr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Eleanor Thomas</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Stacey Charlene Parker (daughter)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3847 - 26th Avenue, Temple Hills, Maryland 20748</b>			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metropolitan Crematory</b>		Date <b>Jan. 5, 1999</b>		20c. Location - City or Town, State <b>Alexandria, Virginia</b>	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Robert G. Mason Funeral Home, Inc. 1661 Good Hope Road, S.E.; Washington, D.C. 20020</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>HYPERTROPHIC CARDIOMYOPATHY</b> Due to (or as a consequence of):  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  <b>COCAINE USAGE</b> Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):							Approximate Interval Between Onset and Death
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>COCAINE USAGE</b>						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
	24a. Was an autopsy performed? <b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>						24b. Were autopsy findings available prior to completion of cause of death? <b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>SCENE</b>					
	27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier 				29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>DECEMBER 27, 1998</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>J. Aaron Locke, MD 111 Penn Street, Baltimore, Maryland 21201</b>							
State Registrar	31. Date filed (Month, Day, Year) <b>JAN 05 1999</b>				32. Registrar's Signature 			





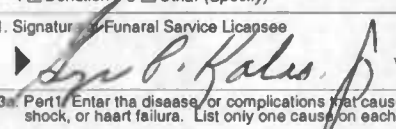
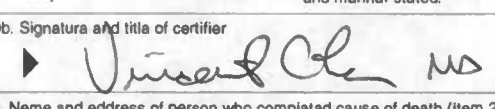

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
**Certificate of Death**

Reg. No.

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) <b>Etta M. Bohm</b>		2. Date of Death Month <b>December</b> Day <b>20</b> , Year <b>1998</b>		3. Time of Death <b>8:20 P.M.</b>	
4a. Facility Name (If not institution, give street and number) <b>960 Stable Ct.</b>		4b. City, Town, or Location of Death <b>Davidsonville</b>		4c. County of Death <b>Anne Arundel</b>	
5. Social Security Number <b>244-32-7776</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>71</b> Yrs.	
8. Date of Birth (Month, Day, Year) <b>Nov. 23, 1927</b>		9. Birthplace (State or Foreign Country) <b>North Carolina</b>			
Usual Residence of Decedent					
10a. State <b>Maryland</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Davidsonville</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number <b>960 Stable Court</b>		10f. Zip Code <b>21035</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>					
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Supervisor</b>		16b. Kind of Business/Industry <b>Bell Atlantic Telephone</b>	
17. Father's Name (First, Middle, Last) <b>James Rufus Furr</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Aggie Mannor</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Wayne Carey/Friend</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Same as item 10</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Maryland Veteran's Cemetery 12/23/98 Cheltenham, MD.</b>		20c. Location - City or Town, State	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>George P. Kalas Funeral Home, P.A. 2973 Solomons Island Rd., Edgewater, MD 21037</b>			
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)		a. <b>METASTATIC GASTRIC CARCINOMA</b>			
		Due to (or as a consequence of):			
		b. Due to (or as a consequence of):			
		c. Due to (or as a consequence of):			
		d. Due to (or as a consequence of):			
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier 		29c. License number <b>D38129</b>		29d. Date signed (Month, Day, Year) <b>DEC 21, 1998</b>	
30. Name and address of person who completed cause of death (item 23a) (Type, Print) <b>VINCENT CHEN, MD 9131 PISCATAWAY ROAD #600 CLINTON, MD 20735</b>					
31. Date filed (Month, Day, Year) <b>DEC 21 1998</b>		32. Registrar's Signature 			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

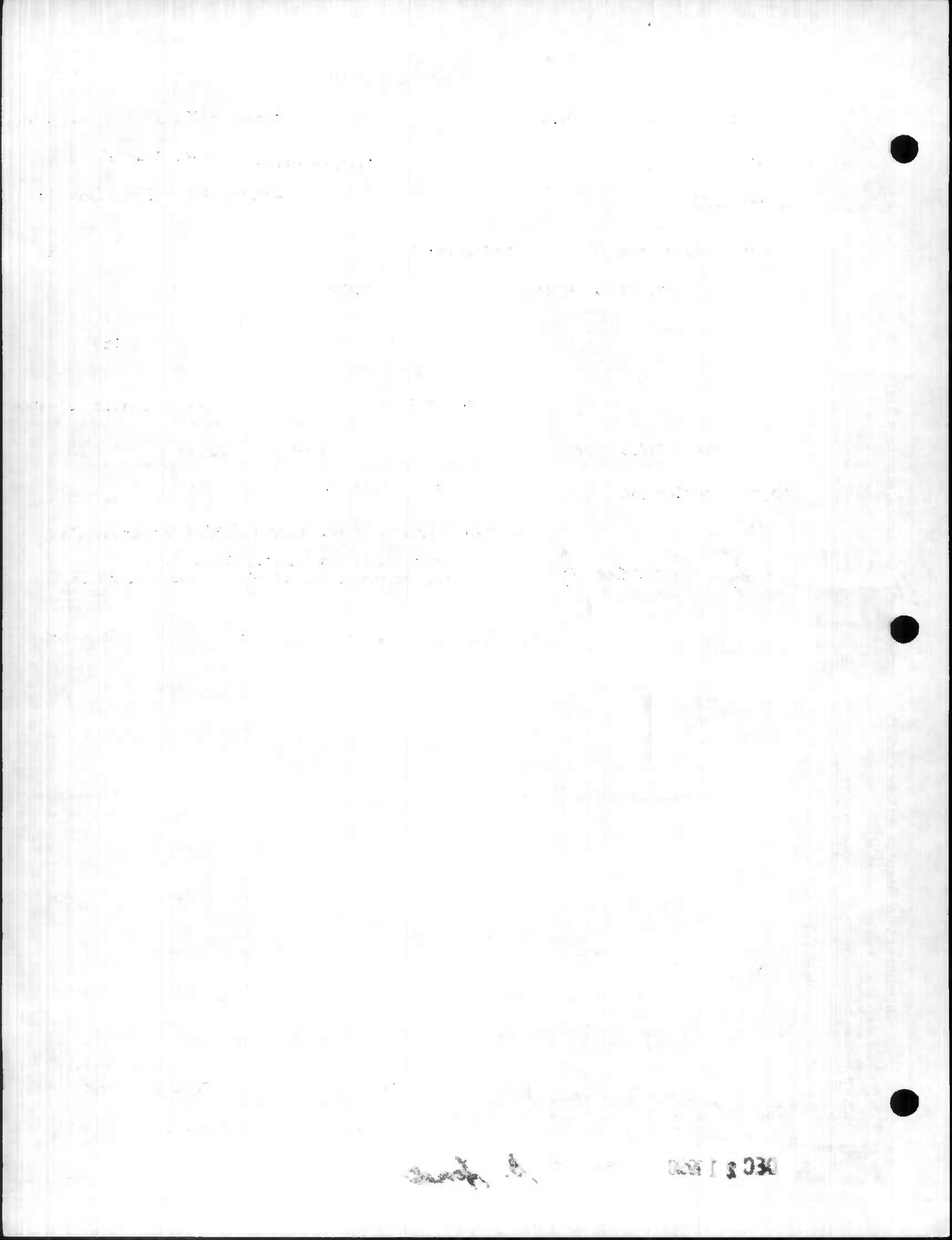
Baltimore, Maryland 21215-0020  
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

State  
Registrar



2001

2001

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41073

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last)

CASSANDRA JOHNSON BROWN

2. Date of Death

Month Day Year  
December 19 1998

3. Time of Death

3:25 AM

4a. Facility Name (If not institution, give street and number)

17003 Village Drive West

4b. City, Town, or Location of Death

Upper Marlboro

4c. County of Death

Prince George's

5. Social Security Number

212-68-5725

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

42 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

September 28, 1956

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Upper Marlboro

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

17003 Village Drive West

10f. Zip Code

20772

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2 years

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Ernest N. Johnson

18. Mother's Name (First, Middle, Maiden Surname)

Annie Pelder

19a. Informant's Name/Relationship (Type, Print)

Michael T. Brown/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

17003 Village Drive West, Upper Marlboro, MD 20772

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Harmony Memorial Park

Date

12/23 1998

20c. Location - City or Town, State

Landover, Maryland

21. Signature of Funeral Service Licensee

Nancy A. Perentie

22. Name and Address of Facility

J. B. JENKINS FUNERAL HOME  
7474 Landover Road, Landover, Maryland 20785

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

GASTRIC CANCER

Approximate Interval Between Onset and Death

6 mos

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Stephen Staal MD

29c. License number

018219

29d. Date signed (Month, Day, Year)

12/21/98

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

1221 MERCANTILE LANE LARGO MD 20774

31. Date filed (Month, Day, Year)

DEC 21 1998

32. Registrar's Signature

[Signature]

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41074

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

William Bright, Jr.

2. Date of Death

December 16 1998

3. Time of Death

1:46AM

4a. Facility Name (If not institution, give street and number)

Prince George's Hospital Center

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

214-34-6151

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

61

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

March 22 1937

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

10b. County

10c. City, Town or Location

10d. Inside City Limits

Maryland Prince George's

Capitol Heights

1 ☒ Yes 2 ☐ No

10e. Street and Number

1213 Dunbar Oaks Drive

10f. Zip Code

20743

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12th

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Sanitation Worker

16b. Kind of Business/Industry

Dept. of Public Works

17. Father's Name (First, Middle, Last)

William Bright, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Myrtle Parran

19a. Informant's Name/Relationship (Type, Print)

Mary F. Buck - Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1213 Dunbar Oaks Dr., Capitol Heights, MD 20743

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Harmony Memorial Park

Date

12/21/98

20c. Location - City or Town, State

Landover, MD

21. Signature of Funeral Service Licensee

John T. Stewart, III

22. Name and Address of Facility

Stewart Funeral Home

4001 Benning Rd., N.E. Wash., D.C. 20019

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

End Stage Kidney disease

a. Due to (or as a consequence of):

Hypertension

b. Due to (or as a consequence of):

Diabetes

c. Due to (or as a consequence of):

Congestive heart failure

d. Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy

performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings

available prior to

completion of cause

of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical

examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

Investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of

injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office

building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J.D. Alleyne, M.D.

29c. License number

D51006

29d. Date signed (Month, Day, Year)

December 17, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J.D. Alleyne, M.D. Prince George's Hospital Center, Cheverly, MD

31. Date filed (Month, Day, Year)

DEC 21 1998

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-691-0020.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41075

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MARGRIE JOHNSON BROWN

2. Date of Death

Month Day Year  
12 16 98

3. Time of Death

8:55PM

4a. Facility Name (If not institution, give street and number)

FORT WASHINGTON HOSPITAL

4b. City, Town, or Location of Death

FORT WASHINGTON PRINCE GEORGES

4c. County of Death

PRINCE GEORGES

Funeral  
Director

5. Social Security Number

218-34-6703

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

APRIL 22, 1922

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

CHARLES

10c. City, Town or Location

WALDORF

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

10223 BRIARWOOD PLACE

10f. Zip Code

20601

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

5TH GRADE

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

CUSTODIAN

16b. Kind of Business/Industry

BOARD OF EDUCATION

17. Father's Name (First, Middle, Last)

WESLEY JOHNSON

18. Mother's Name (First, Middle, Maiden Surname)

ELVIRA STARKS JOHNSON

19a. Informant's Name/Relationship (Type, Print)

ETHEL HOLTON / DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10223 BRIARWOOD PLACE, WALDORF, MARYLAND 20601

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

OAK GROVE CHURCH CEMETERY

Date

12/21/98

20c. Location - City or Town, State

GRAYTON, MARYLAND

21. Signature of Funeral Service Licensee

Lidia C. Thornton Johnson

22. Name and Address of Facility

THORNTON FUNERAL HOME, P.A.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Lidia C. THORNTON JOHNSON M00583 3439 LIVINGSTON ROAD, INDIAN HEAD, MD. 20640

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Congestive Heart Failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Keith Benton, MD

29c. License number

D36562

29d. Date signed (Month, Day, Year)

December 18, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Keith Benton

11701 Livingston Rd # 208

FORT WASHINGTON, MD

31. Date filed (Month, Day, Year)

DEC 23 1998

32. Registrar's Signature

State  
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



100-100000

100-100000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

8 41076

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Ralph Couchman

2. Date of Death  
Month Day Year  
December 28, 19983. Time of Death  
11:00 P.M.

4a. Facility Name (If not Institution, give street and number)

Frederick Memorial Hospital

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

5. Social Security Number

214-09-9043

6. Sex  
1 ☒ M 2 ☐ F7. Age (In yrs. last birthday)  
Yrs. 90If Under 1 Year  
Months DaysIf Under 24 Hrs.  
Hours Min.8. Date of Birth  
(Month, Day, Year)

Dec 22 1908

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10e. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1613 Sherman Avenue

10f. Zip Code

21740

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
0-8College (1-4 or 5+)  
016a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Expediter

16b. Kind of Business/Industry

Aircraft Mfg.

17. Father's Name (First, Middle, Last)

Benjamin S. Couchman

18. Mother's Name (First, Middle, Maiden Surname)

Jennie Small

19a. Informant's Name/Relationship (Type, Print)

Sandra Fout - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7411-C Round Hill Road Frederick, Md. 21702

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Rose Hill Cemetery

Date

12/31/98

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee

Scott Minnich

22. Name and Address of Facility

Minnich Funeral Home

415 E. Wilson Blvd. Hagerstown, Md. 21740

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.

CVA

a. Due to (or as a consequence of):

b. Cerebral vascular disease

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending  
Investigation 6 ☐ Could not be  
determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Robert Scovner M.D.

29c. License number

D14724

29d. Date signed (Month, Day, Year)

12/28/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert Scovner, M.D. 1603B Berry Rose Court, Frederick, Md.

31. Date filed (Month, Day, Year)

DEC 30 1998

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 41077

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MARGARET ETTA CARPENTER

2. Date of Death

Month Day Year  
DECEMBER 24, 1998 4:27 PM

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

WILLIAMSPORT RETIREMENT VILLAGE

4b. City, Town, or Location of Death

WILLIAMSPORT

4c. County of Death

WASHINGTON

5. Social Security Number

212-38-2636

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

92 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
OCT 7 1906

9. Birthplace (State or Foreign Country)

Statehine, PA

Usual Residence of Decedent

10a. State

MD

10b. County

WASHINGTON

10c. City, Town or Location

WILLIAMSPORT

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

136 N ARTIZAN ST

10f. Zip Code

21795

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOME MAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

GEORGE FREDERICK TRESSLER

18. Mother's Name (First, Middle, Maiden Surname)

ELIZABETH LEDY

19a. Informant's Name/Relationship (Type, Print)

JEAN A POOLE / DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11338 ASTON RD CLEAR SPRINGS MD 21722

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

REST HAVEN CEMETERY

Date

12/29

20c. Location - City or Town, State

HAGERSTOWN MD.

21. Signature of Funeral Service Licensee

John C. Lynch

22. Name and Address of Facility MILLER GROVE FUNERAL HOME

521 S WASHINGTON ST GREENCASTLE PA

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. RENAL FAILURE

Due to (or as a consequence of):

DAYS

b. DEHYDRATION

Due to (or as a consequence of):

DAYS

c. DYSPHAGIA

Due to (or as a consequence of):

~2 WEEKS

d. CEREBROVASCULAR ACCIDENT

Due to (or as a consequence of):

~2 WEEKS

e. HYPERTENSION

YEARS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CORONARY ARTERY DISEASE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

STAFF PHYSICIAN

29c. License number

D42046

29d. Date signed (Month, Day, Year)

December 25, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GRACE BROOKE HUFFMAN, M.D. 18100 SLADE SCHOOL ROAD SANDY SPRING MARYLAND 20860

31. Date filed (Month, Day, Year)

DEC 28 1998

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

10-15-54

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 41078

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Robert CATON</b>				2. Date of Death Month <b>12</b> Day <b>01</b> Year <b>98</b>				3. Time of Death <b>1100</b>						
	4a. Facility Name (If not institution, give street and number) <b>UNIVERSITY OF MARYLAND</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>				4c. County of Death <b>BALT. CITY</b>						
Funeral Director	5. Social Security Number <b>232-32-5412</b>		6. Sex <b>10M</b> 20F		7. Age (In yrs. last birthday) <b>69</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>NOV. 13, 1929</b>		9. Birthplace (State or Foreign Country) <b>WEST VIRGINIA</b>						
	Usual Residence of Decedent														
10a. State <b>WV</b>		10b. County <b>BERKELEY</b>		10c. City, Town or Location <b>MARTINSBURG</b>				10d. Inside City Limits 10 Yes 20 No <b>X</b>							
10e. Street and Number <b>RT. 1, BOX 179M</b>				10f. Zip Code <b>25401</b>				10g. Citizen of What Country? <b>USA</b>							
11. Marital Status 10 Never Married 20 Married 30 Widowed 40 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 10 Yes 20 No If Yes, Give Year or Dates: <b>1948-1952</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 10 Yes 20 No <b>X</b> Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>							
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>INVENTORY CLERK</b>				16b. Kind of Business/Industry <b>A T &amp; T</b>							
17. Father's Name (First, Middle, Last) <b>CHARLES B. CATON</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>MARY KOONTZ</b>											
19a. Informant's Name/Relationship (Type, Print) <b>HELEN CATON/WIFE</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>RT. 1, BOX 179M, MARTINSBURG, WV 25401</b>											
20a. Method of Disposition 10 Burial 20 Cremation 30 Removal from State 40 Donation 50 Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>ROSEDALE CEMETERY</b>		Date <b>12/4/98</b>		20c. Location - City or Town, State <b>MARTINSBURG, WV</b>									
21. Signature of Funeral Service Licensee <b>Charles M. Brown</b>				22. Name and Address of Facility <b>BROWN FUNERAL HOME, 327 W. KING STREET PO BOX 821, MARTINSBURG, WV 25402</b>											
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death					
Immediate Cause (Final disease or condition resulting in death) <b>e. CARDIAC ARREST</b>										<b>1 HOUR</b>					
Due to (or as a consequence of): <b>b. STAPH SEPTICEMIA</b>										<b>7 days</b>					
Due to (or as a consequence of): <b>c.</b>															
Due to (or as a consequence of): <b>d.</b>															
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 10 Yes 20 No <b>X</b> 30 Probably 40 Unknown					
24a. Was an autopsy performed? 10 Yes 20 No <b>X</b>										24b. Were autopsy findings available prior to completion of cause of death? 10 Yes 20 No					
25. Was case referred to medical examiner? 10 Yes 20 No <b>X</b>		26. Place of Death (Check only one) Hospital: 10 Inpatient 20 ER/Outpatient 30 DOA Other: 40 Nursing Home 50 Residence 80 Other (Specify)													
27. Manner of Death 10 Natural 50 Pending investigation 20 Accident 60 Could not be determined 30 Suicide 40 Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 10 Yes 20 No		28d. Describe how injury occurred							
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier (Check only one) <b>X</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										29b. Signature and title of certifier <b>Joseph J. Maloney</b>		29c. License number <b>P11411</b>		29d. Date signed (Month, Day, Year) <b>12/28/98</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>J. MALOSSO, UNIV. OF MARYLAND</b>															
31. Date filed (Month, Day, Year) <b>JAN 04 1999</b>		32. Registrar's Signature <b>B. Sparks</b>													

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "Natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 41079

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>SAMUEL Robert COFFIN</b>				2. Date of Death Month Day Year <b>DECEMBER 27 1998</b>		3. Time of Death <b>10:45 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Berlin Nursing and Rehabilitation Center</b>				4b. City, Town, or Location of Death <b>Berlin</b>		4c. County of Death <b>Worcester</b>	
Funeral Director	5. Social Security Number <b>220-01-9738</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>81</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Nov. 25, 1917</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10. Usual Residence of Decedent 10e. State <b>Md.</b> 10b. County <b>Worcester</b> 10c. City, Town or Location <b>Ocean City</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number <b>10128 Silver Point Lane</b>		10f. Zip Code <b>21842</b>		10g. Citizen of What Country? <b>US</b>				
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WWII Korea</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>II</b> College (1-4 or 5+)		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Co-Owner</b>		16b. Kind of Business/Industry <b>Drug Store</b>				
17. Father's Name (First, Middle, Last) <b>Clinton Coffin</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Sarah Massey</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Evelyn Coffin (wife)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10128 Silver Point Lane, Ocean City, Md. 21842</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Evergreen Cemetery</b>		20c. Date <b>12-30-98</b>		20d. Location - City or Town, State <b>Berlin, Maryland</b>		
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <b>The Burbage Funeral Home, 108 William St., Berlin, Md. 21811</b>				
23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <i>Chronic Obstructive Pulmonary Disease</i> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):				Approximate Interval Between Onset and Death				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Amputation - Right Hip - Left Kidney</i> <i>COPD with Chronic Fibrosis</i> <i>Nursing Home Dependence</i>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>[Signature]</i>		29c. License number <b>D02026</b>		29d. Date signed (Month, Day, Year) <b>12 28 98</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>FEDERICO G. ARTHE 46 TEAL CIRCLE OCEAN PINES MD 21811 410-641-4400</b>								
31. Date filed (Month, Day, Year) <b>DEC 28 1998</b>				32. Registrar's Signature <i>[Signature]</i>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

2441

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41080

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Pearl Cox</b>				2. Date of Death Month <b>12</b> Day <b>19</b> Year <b>98</b>				3. Time of Death <b>6:10 pm</b>	
	4a. Facility Name (If not institution, give street and number) <b>Johns Hopkins Bayview Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore</b>				4c. County of Death <b>Baltimore City</b>	
Funeral Director	5. Social Security Number <b>214-12-9505</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>82</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Sep 1, 1916</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <b>MD</b>		10b. County <b>Baltimore City</b>		10c. City, Town or Location <b>Baltimore</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number <b>5009 Frankford Avenue</b>				10f. Zip Code <b>21206</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> Collega (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Laborer</b>				16b. Kind of Business/Industry <b>Laboratory</b>			
	17. Father's Name (First, Middle, Last) <b>Bennett Thompson</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Henrietta Cardwell</b>					
To Be Completed by Physician/Medical Examiner	19e. Informant's Name/Relationship (Type, Print) <b>Mrs. Maryellen Burns (Sister)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7200 Third Avenue Sykesville, MD 21784</b>					
	20e. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Springfield Cemetery</b>		Date <b>12/22/98</b>		20c. Location - City or Town, State <b>Sykesville, MD</b>			
	21. Signature of Funeral Service Licensee <b>Brian L. Haight</b>				22. Name and Address of Facility <b>HAIGHT FUNERAL HOME &amp; CHAPEL (Box 195) Sykesville, MD 21784 (410)-795-1400</b>					
	23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>pneumonia</b> Due to (or as a consequence of):  Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Dementia, hx CVA, hx coronary artery disease</b> Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Dementia, hx CVA, hx coronary artery disease</b>						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 8 <input type="checkbox"/> Could not be determined		28e. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred	
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Hyon Seo M.D.</b>		29c. License number <b>96712</b>		29d. Date signed (Month, Day, Year) <b>12-19-98</b>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Hyon Seo 4940 Eastern Ave Baltimore, MD 21224.</b>									
	31. Date filed (Month, Day, Year) <b>DEC 22 1998</b>		32. Registrar's Signature <b>B. Sparks</b>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 41081

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) George Joseph Carlin				2. Date of Death Month: December Day: 18 Year: 1998		3. Time of Death 4:37AM	
	4a. Facility Name (If not Institution, give street and number) 9820 Parsonage Lane				4b. City, Town, or Location of Death New Windsor		4c. County of Death Frederick	
Funeral Director	5. Social Security Number 577-38-7136		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 84 Yrs.		8. Date of Birth (Month, Day, Year) Feb. 5, 1914	
	9. Birthplace (State or Foreign Country) Washington DC		10a. State MD		10b. County Frederick		10c. City, Town or Location New Windsor	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 9820 Parsonage Lane		10f. Zip Code 21776		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) postal clerk		16b. Kind of Business/Industry civil service			
	17. Father's Name (First, Middle, Last) George J. Carlin				18. Mother's Name (First, Middle, Maiden Surname) Sadie Luckett			
	19a. Informant's Name/Relationship (Type, Print) Myrtle W. Carlin - wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9820 Parsonage Lane, New Windsor, MD 21776			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) St. Peter's Cemetery		Date Dec. 21 1998		20c. Location - City or Town, State Libertytown, MD	
	21. Signature of Funeral Service Licensee <i>Therese D. Hartzler</i>		22. Name and Address of Facility Hartzler Funeral Home Rt. 26, Libertytown, MD 21762					
	23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. CARCINOMA OF PROSTATE Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
Physician /Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred					
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier Arthur L. Ludom, MD PHYSICIAN		29c. License number D21155		29d. Date signed (Month, Day, Year) 12/18/98			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARTHUR L. LUDOM, 904 WASHINGTON RD WESTMINSTER, MD 21157							
	31. Date filed (Month, Day, Year) DEC 22 1998		32. Registrar's Signature <i>Benjamin S. Sparks</i>					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar



98 41082

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Thomas Parrian Cooksey				2. DATE OF DEATH MONTH DAY YEAR December 27, 1998		3. TIME OF DEATH 6:20 A M	
4. SOCIAL SECURITY NUMBER 216-44-7090		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 88 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Nov. 8, 1910	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) St. Mary's Nursing Home		9b. CITY, TOWN OR LOCATION OF DEATH Leonardtwn	
9c. COUNTY OF DEATH St. Mary's				10a. STATE Maryland		10b. COUNTY St. Mary's	
10c. CITY, TOWN OR LOCATION Chaptico				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER P. O. Box 572				10f. ZIP CODE 20621		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9		16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Steamfitter		17. KIND OF BUSINESS/INDUSTRY Federal Government			
17. FATHER'S NAME (First, Middle, Last) Thomas Vivian Cooksey				18. MOTHER'S NAME (First, Middle, Maiden Surname) Lucy J. Murphy			
19a. INFORMANT'S NAME (Type/Print) Kay Jones - Daughter				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P. O. Box 572, Chaptico, MD 20621			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) St. Charles Cemetery		20c. LOCATION — City or Town, State Glymont, Indian Head, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE John P. Knisley M01164				22. NAME AND ADDRESS OF FACILITY Huntt Funeral Home, Inc. P. O. Box 156, Waldorf, MD 20604-0156			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Intracerebral bleed							about 1 week
b. Multiple myeloma							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Dr. M. A. Rahman, MD				29c. LICENSE NUMBER D50044		29d. DATE SIGNED (Month, Day, Year) 12/28/1998	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. M. A. Rahman, 22650 Cedar Lane, Leonardtown, MD 20650							
31. DATE FILED (Month, Day, Year) DEC 31 1998		32. REGISTRAR'S SIGNATURE B. Sparks					

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41083

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JOSEPH MARCO CORNACHIA

2. Date of Death

Month Day Year  
Dec 25, 1998

3. Time of Death

2:50 pm

4a. Facility Name (If not institution, give street and number)

309 S. CEDAR STREET

4b. City, Town, or Location of Death

CUMBERLAND

4c. County of Death

ALLEGANY

Funeral  
Director

5. Social Security Number

215-56-7748

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

48

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Jun 30, 1950

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Allegany

10c. City, Town or Location

Cumberland

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

309 S. Cedar Street

10f. Zip Code

21502

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Electrician

16b. Kind of Business/Industry

CSXT Corporation

17. Father's Name (First, Middle, Last)

Frank Cornachia

18. Mother's Name (First, Middle, Maiden Surname)

Mary Alice (McDonald)

19a. Informant's Name/Relationship (Type, Print)

Tammy R. Cornachia--daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 354; Wiley Ford, WV 26767

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Mary's Cemetery

Date

12/29

20c. Location - City or Town, State

Cumberland, MD

21. Signature of Funeral Service Licensee

Nicholas J. Scarpelli

22. Name and Address of Facility

Scarpelli Funeral Home, P.A.

Cumberland, MD 21502

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Alcohol Abuse Syndrome w/ complications

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Uk yrs.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Paul Snow

29c. License number

09157

29d. Date signed (Month, Day, Year)

Dec 26, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Paul Snow; 124 W. Third Street; Cumberland, MD 21502

31. Date filed (Month, Day, Year)

DEC 29 1998

32. Registrar's Signature

P. Snow

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41084

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MARY FRANCES CUFF

2. Date of Death  
Month Day Year  
December 17, 19983. Time of Death  
1:45 PM

4a. Facility Name (If not institution, give street and number)

MEMORIAL HOSPITAL

4b. City, Town, or Location of Death

CUMBERLAND

4c. County of Death

ALLEGANY

Funeral  
Director

5. Social Security Number

212-80-3651

6. Sex  
1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

62

If Under 1 Year  
Months DaysIf Under 24 Hrs.  
Hours Min.8. Date of Birth  
(Month, Day, Year)

May 21, 1936

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10e. State

MD

10b. County

Allegany

10c. City, Town or Location

Cumberland

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

10102 Country Club Road

10f. Zip Code

21502

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Martin D. Cuff

18. Mother's Name (First, Middle, Maiden Surname)

Helen Cecil

19a. Informant's Name/Relationship (Type, Print)

Paula O'Brien--sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

309 Woodland Way; Romney, WV 26757

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Sunset Memorial Park

Date

12/21

20c. Location - City or Town, State

Cumberland, MD

21. Signature of Funeral Service Licensee

Nicholas J. Scarpelli

22. Name and Address of Facility

Scarpelli Funeral Home, P.A.  
Cumberland, MD 2150223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Anoxic encephalopathy

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

9 days

b. Aspiration syndrome

Due to (or as a consequence of):

9 days

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Seizures

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation  
6 ☐ Could not be determined28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

D. Shah MD

29c. License number

D23334

29d. Date signed (Month, Day, Year)

December 18th 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DINESH SHAH, M.D., JOHNSON HEIGHTS MEDICAL BLDG., CUMBERLAND MD

31. Date filed (Month, Day, Year)

DEC 21 1998

32. Registrar's Signature

D. Shah

State  
RegistrarBaltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

MARY CUFF 212-80-3651

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Amended # 14 Nbs,  
12/21/98, Allegany County

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41085

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) HAZEL B. COMBS				2. Date of Death Month Day Year DECEMBER 18, 1998				3. Time of Death 8:10 PM							
	4a. Facility Name (If not institution, give street and number) Sacred Heart Hospital				4b. City, Town, or Location of Death Cumberland				4c. County of Death Allegany							
Funeral Director	5. Social Security Number 236 36 2132		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 89 Yrs.		8. Date of Birth (Month, Day, Year) 12-2-09		9. Birthplace (State or Foreign Country) WV							
	Usual Residence of Decedent															
To Be Completed by Funeral Director	10a. State MD		10b. County Allegany		10c. City, Town or Location Frostburg				10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No							
	10e. Street and Number Frostburg Village Nursing Center 1 Kaylor Circle				10f. Zip Code 21532		10g. Citizen of What Country? USA									
	11. Marital Status <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White White								
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) unknown				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) None				16b. Kind of Business/Industry Disabled							
	17. Father's Name (First, Middle, Last) Jonas L. Combs				18. Mother's Name (First, Middle, Maiden Surname) Martha E. Bean											
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Linda M. Winters, Great niece				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16009 Waterfall Road, Haymarket, VA 20169											
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Porter Cemetery		Date 12-22-98		20c. Location - City or Town, State Hyndman RD, PA									
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Harvey H. Zeigler Funeral Home Hyndman, PA 15545											
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CHRONIC OBSTRUCTIVE LUNG DISEASE Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death About 10 yrs					
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CORONARY ARTERY DISEASE CONGESTIVE HEART FAILURE, DIABETES MELLITUS CHRONIC KIDNEY FAILURE										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
State Registrar	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)													
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred							
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)													
	29a. Certifier (Check only one) 1 <input type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										29b. Signature and title of certifier 		29c. License number D 26907		29d. Date signed (Month, Day, Year) DECEMBER 19, 1998	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HARJIT SIDHU M.D. 925 BISHOP WALSH DRIVE CUMBERLAND, MD. 21502															
31. Date filed (Month, Day, Year) DEC 21 1998										32. Registrar's Signature 						





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 41086

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Charles Patrick Cockrell</b>				2. Date of Death Month Day Year <b>December 12, 1998</b>				3. Time of Death <b>12:00 PM</b>			
	4a. Facility Name (If not institution, give street and number) <b>Bradford Oaks Nursing Home</b>				4b. City, Town, or Location of Death <b>Clinton</b>				4c. County of Death <b>Prince George's</b>			
Funeral Director	5. Social Security Number <b>579-56-7955</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>53</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Dec. 29, 1944</b>		9. Birthplace (State or Foreign Country) <b>Washington DC</b>			
	Usual Residence of Decedent											
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>Prince George's</b>		10c. City, Town or Location <b>Upper Marlboro</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	10e. Street and Number <b>6219 Buttercup Lane</b>				10f. Zip Code <b>20772</b>		10g. Citizen of What Country? <b>U.S.A.</b>					
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9th</b> Collage (1-4 or 5+) <b>N/A</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Painter</b>			16b. Kind of Business/Industry <b>Sub. Conctactor</b>				
	17. Father's Name (First, Middle, Last) <b>Acie William Cockrell</b>				18. Mother's Name (First, Middle, Maiden Sumama) <b>Mary Shealey</b>							
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Rose Mary Miller (Sister)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6219 Buttercup Lane Upper Marlboro, Maryland 20772</b>							
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Lee Crematory</b>		Dec. 15, 1998		20c. Location - City or Town, State <b>Clinton, Maryland</b>			
	21. Signature of Funeral Service Licensee <b>Stk S. Smith</b>				22. Name and Address of Facility <b>Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD 20735</b>							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Carcinoma of the Lung</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>										Approximate interval Between Onset and Death <b>Months</b>	
	Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <b>William J. Oetgen</b>				29c. License number <b>D 16129</b>		29d. Date signed (Month, Day, Year) <b>Dec 15, 1998</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>William J. Oetgen, M.D. 9131 Piscataway Road, #600, Clinton, Maryland 20735</b>												
31. Date filed (Month, Day, Year) <b>DEC 17 1998</b>				32. Registrar's Signature <b>B. Spauld</b>								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 41087

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Samuel Eugene Decker</b>				2. Date of Death Month <b>December</b> Day <b>24</b> , Year <b>1998</b>				3. Time of Death <b>3:30pm</b>	
	4a. Facility Name (If not institution, give street and number) <b>1079 Magothy View</b>				4b. City, Town, or Location of Death <b>Annapolis</b>				4c. County of Death <b>Anne Arundel</b>	
Funeral Director	5. Social Security Number <b>219-20-3833</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>70</b> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) <b>May 8, 1928</b>		9. Birthplace (State or Foreign Country) <b>MD</b>		10a. State <b>MD</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Annapolis</b>	
Usual Residence of Decedent										
10a. State <b>MD</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Annapolis</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>1079 Magothy View</b>				10f. Zip Code <b>21401</b>				10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>white</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8th grade</b> College (1-4 or 5+) <b>0</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Supervisor</b>				16b. Kind of Business/Industry <b>Research company</b>		
17. Father's Name (First, Middle, Last) <b>Charles Russell Decker</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Ellen Ruth Snook</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Betty Decker</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1079 Magothy View Annapolis, MD. 21401</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Shantown Cem.</b>				Date <b>December 29, 1998</b>		20c. Location - City or Town, State <b>Big Pool, MD</b>
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility <b>Donald Edwin Thompson Funeral Home, Inc. P.O. Box 310 Clear Spring, MD 21722</b>				
23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <b>Cardiac arrest</b> Due to (or as a consequence of): b. <b>Ischemic Cardio-Myopathy</b> Due to (or as a consequence of): c. <b>ASCVD</b> Due to (or as a consequence of): d. <b>Diabetes Mellitus</b>										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier 				29c. License number <b>1030241</b>				29d. Date signed (Month, Day, Year) <b>12 27 98</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>J. Schmittlein, MD, Ritchie Hwy. Serv. Pk. MD 21146</b>										
31. Date filed (Month, Day, Year) <b>12 27 JAN 4 1999</b>				32. Registrar's Signature 						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 41088

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Patricia Lee Dennis</b>				2. Date of Death Month <b>12</b> Day <b>22</b> Year <b>1998</b>		3. Time of Death <b>7:40 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>231 Canal Park Drive</b>				4b. City, Town, or Location of Death <b>Salisbury</b>		4c. County of Death <b>Wicomico</b>	
Funeral Director	5. Social Security Number <b>212-40-8532</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>56</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>1/13/1942</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent							
10a. State <b>MD</b>		10b. County <b>Wicomico</b>		10c. City, Town or Location <b>Salisbury</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>231 Canal Park Drive</b>				10f. Zip Code <b>21804</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>white</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>realtor</b>			16b. Kind of Business/Industry <b>realtor</b>	
17. Father's Name (First, Middle, Last) <b>George W. Wilkinson</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Eunice V. Peacock</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Benjamin W. Dennis (spouse)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>231 Canal Park Dr., Salisbury, MD 21804</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Wicomico Mem. Gardens</b>		Date <b>12/28/98</b>		20c. Location - City or Town, State <b>Salisbury, MD</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Holloway Funeral Home P.A. 501 Snow Hill Rd., Salisbury, MD 21804</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>metastatic Breast Cancer</b>  Due to (or as a consequence of):  Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):								Approximate Interval Between Onset and Death <b>6 years</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier  M.D.		29c. License number <b>030690</b>		29d. Date signed (Month, Day, Year) <b>12/28/98</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>James E. Martin, M.D., 145 E. Carroll St., Salisbury, MD.</b>								
31. Date filed (Month, Day, Year) <b>DEC 28 1998</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 41089

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last) HORACE L. DAUGHERTY  
2. Date of Death Month Day Year DECEMBER 22, 1998  
3. Time of Death 6:20 AM

4a. Facility Name (If not institution, give street and number) 28149 NANTICOKE RD  
4b. City, Town, or Location of Death SALISBURY  
4c. County of Death WICOMICO

Funeral  
Director

5. Social Security Number 241-32-7946  
6. Sex 1 ☒ M 2 ☐ F  
7. Age (In yrs. last birthday) 81 Yrs.  
8. Date of Birth (Month, Day, Year) DEC. 23, 1916  
9. Birthplace (State or Foreign Country) NORTH CAROLINA

Usual Residence of Decedent  
10a. State MARYLAND  
10b. County WICOMICO  
10c. City, Town or Location SALISBURY  
10d. Inside City Limits 1 ☐ Yes 2 ☒ No

10e. Street and Number 28149 NANTICOKE RD.  
10f. Zip Code 21801  
10g. Citizen of What Country? U.S.A.

11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced  
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No WWII  
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:  
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 Collage (1-4 or 5+) 6  
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SALESMAN  
16b. Kind of Business/Industry COFFEE DISTRIBUTOR

17. Father's Name (First, Middle, Last) HORACE DAUGHERTY  
18. Mother's Name (First, Middle, Maiden Surname) LYDIA HEATH

19a. Informant's Name/Relationship (Type, Print) RODNEY DAUGHERTY - SON  
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4021 DOGWOOD CT. PORT REPUBLIC, MD 20676

20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) ENTOMBMENT  
20b. Place of Disposition (Name of cemetery, crematory or other place) SPRINGHILL MEM. GARDENS  
20c. Location - City or Town, State 12-26-98 HEBRON, MD

21. Signature of Funeral Service Licensee B. Keith Phym CFSP  
22. Name and Address of Facility 705 E. MAIN ST. SALISBURY, MD 21804 BOUNDS FUNERAL HOME, INC.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  
Immediate Cause (Final disease or condition resulting in death) a. C A STOMACH  
Due to (or as a consequence of):  
b. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d. Due to (or as a consequence of):  
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last {  
Approximate Interval Between Onset and Death 1 yr

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. unknown  
23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No  
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No  
26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)  
27. Manner of Death 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined  
28a. Date of Injury (Month, Day Year)  
28b. Time of Injury M  
28c. Injury at Work? 1 ☐ Yes 2 ☐ No  
28d. Describe how injury occurred  
28e. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier  
29c. License number D47637  
29d. Date signed (Month, Day, Year) 12-23-98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOSEPH INZERILLO, MD 106 MILFORD ST. SALISBURY, MD 21804

31. Date filed (Month, Day, Year) DEC 23 1998  
32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

5+1VA

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

88 41090

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Hazel Unive Dean				2. Date of Death Month Day Year December 19 1998				3. Time of Death 2:10 AM	
	4a. Facility Name (If not institution, give street and number) St. Mary's Hospital				4b. City, Town, or Location of Death Leonardtown				4c. County of Death St. Mary's	
Funeral Director	5. Social Security Number 218-30-4126		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 72 Yrs.		8. Date of Birth (Month, Day, Year) May 23, 1926		9. Birthplace (State or Foreign Country) Virginia	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County St. Mary's		10c. City, Town or Location Callaway				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 19989 Piney Point Road				10f. Zip Code 20620		10g. Citizen of What Country? U.S.A.			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (1-4 or 5+) :				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home		
	17. Father's Name (First, Middle, Last) Dallas Sellers				18. Mother's Name (First, Middle, Maiden Surname) Bertie Moore					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Jerry W. Dean/Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19930 Pear Hill Lane, Leonardtown, MD 20650					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Charles Memorial Gardens		20c. Location - City or Town, State 12/22/98 Leonardtown, MD			
	21. Signature of Funeral Service Licensee <i>Michael J. Gardiner</i>				22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, MD 20650					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <i>Cardiopulmonary Failure</i> Due to (or as a consequence of): b. <i>Cerebral Thrombosis</i> Due to (or as a consequence of): c. <i>Generalized Atherosclerosis</i> Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  Approximate Interval Between Onset and Death 2 days 3 days yes.									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Chronic Obstructive Pulmonary Disease</i> <i>Carotid Artery Disease</i>						23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
State Registrar	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DCA		26. Place of Death (Check only one) Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	
	28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	29b. Signature and title of certifier <i>James P. Jarboe M.D.</i>				29c. License number <i>D 06419</i>		29d. Date signed (Month, Day, Year) <i>12-21-98</i>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JAMES P. JARBOE M.D. PHILIP J. BEAN MEDICAL CENTER HOLLYWOOD, MD. 20636									
31. Date filed (Month, Day, Year) DEC 21 1998				32. Registrar's Signature <i>B. Sparks</i>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

HAZEL DEAN

Division of Vital Records, P.O. Box 68760,



Amended to 106 mlu  
12/20/98 Allegany County

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 41091

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MELVIN EDWARD DAWSON

2. Date of Death  
Month Day Year  
DECEMBER 24, 1998

3. Time of Death  
11:25 A.M.

4a. Facility Name (If not institution, give street and number)

MEMORIAL HOSPITAL

4b. City, Town, or Location of Death

CUMBERLAND

4c. County of Death

ALLEGANY

Funeral  
Director

5. Social Security Number

214-07-2838

6. Sex  
☒ M ☐ F

7. Age (In yrs. last birthday)

83

If Under 1 Year  
Months Days

If Under 24 Hrs.  
Hours Min.

8. Date of Birth  
(Month, Day, Year)

JAN. 9, 1915

9. Birthplace (State or Foreign  
Country)

MARYLAND

Usual Residence of Decedent

10a. State

WV

10b. County

MINERAL

10c. City, Town or Location

RIDGELEY

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

40 POTOMAC STREET

10f. Zip Code

26753

21502

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married

☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.  
Armed Forces?

☐ Yes ☒ No

If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No.  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

CHIEF DISPATCHER

16b. Kind of Business/Industry

WESTERN MARYLAND

RAILWAY

17. Father's Name (First, Middle, Last)

KING EDWARD DAWSON

18. Mother's Name (First, Middle, Maiden Surname)

ETHEL MAY DAYTON

19a. Informant's Name/Relationship (Type, Print)

LEROY DAWSON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. BOX 621 - RIDGELEY, WV 26753

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State

☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of  
cemetery, crematory or other place)

FORT ASHBY CEMETERY

Date

12/28/98

20c. Location - City or Town, State

FORT ASHBY, WV

21. Signature of Funeral Service Licensee

*Stacy A. Upchurch*

22. Name and Address of Facility

UPCHURCH FUNERAL HOME, P.A.

202 GREENE ST., CUMBERLAND, MD 21502

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.

Immediate Cause (Final  
disease or condition  
resulting in death)

a. INTRACTABLE CONGESTIVE HEART FAILURE

1 YEAR

Due to (or as a consequence of):

b. PROSTATIC CARCINOMA

1 YEAR

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy  
performed?

☐ Yes ☒ No

24b. Were autopsy findings  
available prior to  
completion of cause  
of death?

☐ Yes ☒ No

25. Was case referred to medical  
examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA

Other: ☐ Nursing Home ☒ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending  
investigation  
☐ Accident ☐ Could not be  
determined  
☐ Suicide ☐ Homicide

28a. Date of Injury  
(Month, Day, Year)

28b. Time of  
Injury

28c. Injury at  
Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)

29a. Certifier  
(Check only  
one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*Stacy A. Upchurch*

29c. License number

D 16041

29d. Date signed (Month, Day, Year)

December 29, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Terry Williams, M.D., Memorial Medical Building, Cumberland, M.D. 21502

State  
Registrar

31. Date filed (Month, Day, Year)

DEC 30 1998

32. Registrar's Signature

*Stacy A. Upchurch*

Division of Vital Records, P.O. Box 68760,

DAWSON, MELVIN 214 07 2838

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.



Amended  
to 198 mlu  
12/30/98 Allegany County

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41092

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

James Dom  
214-16-2300

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician  
/Medical  
Examiner

Funeral  
Director

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last) JAMES CURTIS DOM				2. Date of Death Month Day Year December 28, 1998				3. Time of Death 8:35 p.m.	
4a. Facility Name (If not institution, give street and number) Memorial Hospital & Medical Center				4b. City, Town, or Location of Death Cumberland				4c. County of Death Allegany	
5. Social Security Number 214 16 2300		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 86 Yrs.		8. Date of Birth (Month, Day, Year) 9-21-12		9. Birthplace (State or Foreign Country) PA	
Usual Residence of Decedent				10a. State PA				10b. County Somerset	
10c. City, Town or Location Wellersburg				10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					
10e. Street and Number 12128 Route 160--P. O. Box 56				10f. Zip Code 15564				10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4or 5+) 8				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Mechanic				16b. Kind of Business/Industry Manufacturing	
17. Father's Name (First, Middle, Last) George William Dom				18. Mother's Name (First, Middle, Maiden Surname) Mary Mabel Suder					
19a. Informant's Name/Relationship (Type, Print) Zelda R. Dom, Spouse				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P. O. Box 56, Wellersburg, PA 15564					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Restlawn Memorial Gardens 12-31-98		Date LaVale, MD		20c. Location - City or Town, State			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Harvey H. Zeigler Funeral Home Hyndman, Pennsylvania					
23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. CEREBROVASCULAR ACCIDENT Due to (or as a consequence of): Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death 24 MONTHS	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		26. Place of Death (Check only one) Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day Year)		28b. Time of injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number D14865		29d. Date signed (Month, Day, Year) December 29, 1998			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robustiano Barrera, M.D., Memorial Hospital Medical Building, Cumberland, MD 21502									
31. Date filed (Month, Day, Year) DEC 30 1998		32. Registrar's Signature 							


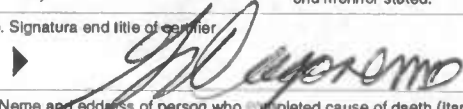





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **98 41093**  
Certificate of Death

Reg. No.

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>JAMES MORTIMER DICKINSON</b>					2. Date of Death Month <b>DECEMBER</b> Day <b>22</b> Year <b>1998</b>		3. Time of Death <b>10:48AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>MEMORIAL HOSPITAL</b>					4b. City, Town, or Location of Death <b>CUMBERLAND</b>		4c. County of Death <b>ALLEGANY</b>	
<b>Funeral Director</b>	5. Social Security Number <b>220-30-8262</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>62</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>OCT 1 1936</b>		9. Birthplace (State or Foreign Country) <b>MARYLAND</b>
	Usual Residence of Decedent								
<b>To Be Completed by Funeral Director</b>	10a. State <b>W. VA.</b>		10b. County <b>MINERAL</b>		10c. City, Town or Location <b>FORT ASHBY</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number <b>116 ERIC LANE</b>				10f. Zip Code <b>26719</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12+</b> College (1-4 or 5+) <b>5</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>PHARMACIST</b>		16b. Kind of Business/Industry <b>PHARMACIST</b>		
	17. Father's Name (First, Middle, Last) <b>ALBERT J. DICKINSON</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>OPAL L. THOMAS</b>			
<b>Physician /Medical Examiner</b>	19a. Informant's Name/Relationship (Type, Print) <b>JOANN DICKINSON</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>WIFE 116 ERIC LANE FORT ASHBY W.VA. 26719</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)					20b. Place of Disposition (Name of cemetery, crematory or other place) <b>SUNSET CEMETERY</b>		20c. Location - City or Town, State <b>DEC 24 1998 CUMBERLAND MARYLAND</b>	
	21. Signature of Funeral Service Licensee 					22. Name and Address of Facility <b>MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
	<div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. <u>Acute Myocardial Infarction</u></p> <p>Due to (or as a consequence of):</p> <p>b. _____</p> <p>Due to (or as a consequence of):</p> <p>c. _____</p> <p>Due to (or as a consequence of):</p> <p>d. _____</p> <p>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</p> </div> <div style="width: 15%; text-align: center;"> <p>Approximate Interval Between Onset and Death</p> <p><u>1 hr</u></p> </div> </div>								
<b>Medical Certification: To Be Completed by Physician/Medical Examiner</b>	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier 					29c. License number <b>D22181</b>		29d. Date signed (Month, Day, Year) <b>Dec 23, 1998</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DR GARY L. WAGONER 925 BISHOP WALSH DRIVE CUMBERLAND MARYLAND 21502</b>									
<b>State Registrar</b>	31. Date filed (Month, Day, Year) <b>DEC 24 1998</b>				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

JAMES DICKINSON  
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41094

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MANSON MATTHIAS DURR

2. Date of Death

December 22 1998

3. Time of Death

0640

4a. Facility Name (If not institution, give street and number)

SACRED HEART HOSPITAL

4b. City, Town, or Location of Death

CUMBERLAND

4c. County of Death

ALLEGANY

Funeral  
Director

5. Social Security Number

217-10-6225

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

MARCH 28, 1914

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ALLEGANY

10c. City, Town or Location

RAWLINGS

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

P.O. BOX 183

10f. Zip Code

21557

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married  
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
8

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

LANDLORD

16b. Kind of Business/Industry

REAL ESTATE

17. Father's Name (First, Middle, Last)

LOUIS DURR

18. Mother's Name (First, Middle, Maiden Surname)

REBECCA MILLER

19a. Informant's Name/Relationship (Type, Print)

MANSON DURR, JR./SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

HILL TOP DRIVE, CUMBERLAND, MD 21502

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

OAK GROVE MENNONITE CEMETERY GRANTSVILLE, MD

Date

DEC 27, 1998

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Douglas A. Haffer

22. Name and Address of Facility

HAFFER CHAPEL OF THE HILLS MORTUARY  
1302 NATIONAL HWY, LA VALE, MD 2150223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. ASPIRATION PNEUMONIA

Due to (or as a consequence of):

b. acute gastrointestinal bleedings

Due to (or as a consequence of):

c. history of peptic ulcer disease

Due to (or as a consequence of):

d.

Approximate  
Interval Between  
Onset and Death

3 1/2 hours

3 1/2 hours

2 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Alzheimer's disease

Parkinson's disease

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☒ No25. Was case referred to medical  
examiner?☒ Yes ☐ No

Hospital:

☐ Inpatient☒ ER/Outpatient☐ DOA

26. Place of Death (Check only one)

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☐ Natural ☐ Pending  
Investigation  
☐ Accident ☐ Could not be  
determined  
☐ Suicide ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury28c. Injury at  
Work?☐ Yes ☒ No

28d. Describe how injury occurred

28a. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☐ Certifying Physician:☒ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Douglas A. Haffer M.D.

29c. License number

009231

29d. Date signed (Month, Day, Year)

December 22 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DONALD F. MANGER 11600 Bedford Road Cumberland Maryland 21502

31. Date filed (Month, Day, Year)

DEC 23 1998

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 41095

Physician /Medical Examiner	1. Decedant's Name (First, Middle, Last) Margaret Louise Duckworth				2. Date of Death Month Day Year Dec 17, 1998				3. Time of Death 5:05 pm							
	4a. Facility Name (If not Institution, give street and number) 1254 Vocke Road				4b. City, Town, or Location of Death LaVale				4c. County of Death Allegany							
Funeral Director	5. Social Security Number 220-28-5282		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 65 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		6. Date of Birth (Month, Day, Year) May 5, 1933		9. Birthplace (State or Foreign Country) MD			
	Usual Residence of Decedent															
To Be Completed by Funeral Director	10a. State MD		10b. County Allegany		10c. City, Town or Location LaVale				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No							
	10e. Street and Number 1254 Vocke Road				10f. Zip Code 21502				10g. Citizen of What Country? USA							
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: white							
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry Own Home							
	17. Father's Name (First, Middle, Last) Joseph Andrew Welch				16. Mother's Name (First, Middle, Maiden Surname) Mary Ellen Farrell											
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Wayne Duckworth-son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1254 Vocke Road LaVale MD 21502											
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Restlawn Memorial Gardens 12/20				20c. Location - City or Town, State LaVale MD							
	21. Signature of Funeral Service Licensee Nicholas J. Scarpelli				22. Name and Address of Facility Scarpelli Funeral Home, P.A. Cumberland MD 21502											
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic Adenocarcinoma Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last															
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No															
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic obstructive pulmonary disease Diabetes mellitus															
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)				28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier Sunil Gupta				29c. License number D 33280				29d. Date signed (Month, Day, Year) Dec 21, 1998			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Sunil Gupta 625 Kent Avenue Cumberland MD 21502															
State Registrar	31. Date filed (Month, Day, Year) DEC 22 1998				32. Registrar's Signature [Signature]											

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



98 41096

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>RONALD DRIVER</b>				2. DATE OF DEATH MONTH <b>DEC</b> DAY <b>21</b> YEAR <b>1998</b>		3. TIME OF DEATH <b>9 AM</b>	
4. SOCIAL SECURITY NUMBER <b>578-70-6143</b>		5. SEX <b>XX M</b> <input type="checkbox"/> F		8. AGE (In yrs. last birthday) <b>44</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>4-25-54</b>	
9a. FACILITY NAME (If not Institution, give street and number) <b>HEARTLAND HEALTHCARE OF HYATTSVILLE</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Hyattsville</b>		9c. COUNTY OF DEATH <b>Prince Georges</b>	
10a. STATE <b>D.C.</b>		10b. COUNTY <b>N/A</b>		10c. CITY, TOWN OR LOCATION <b>Washington</b>		10d. INSIDE CITY LIMITS? <b>XX YES</b> <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>911- Quincy Street, N.W. #1</b>				10f. ZIP CODE <b>20011</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <b>XX Never Married</b> <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <b>XX NO</b> IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <b>XX NO</b> Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>N/A</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Construction Worker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>N/A</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Bernard Saunders</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Barbara J. Driver</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Barbara J. Driver/Mother</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>911- Quincy St., N.W. #1 Washington, D.C. 20011</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <b>XX Cremation</b> <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Riverdale Park Crematory 12/21</b>		20c. LOCATION — City or Town, State <b>Riverdale, Md.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Melita W. Hackett</i>				22. NAME AND ADDRESS OF FACILITY <b>Hackett's Funeral Chapel, Inc. 814- Upshur Street, N.W.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CARDIO RESPIRATORY FAILURE</b> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): <b>ARDS</b> b. DUE TO (OR AS A CONSEQUENCE OF): <b>SEPTIC SHOCK</b> c. DUE TO (OR AS A CONSEQUENCE OF): <b>WAS TUNG SYNDROME</b> d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <b>XX NO</b>				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <b>XX NO</b>			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <b>XX NO</b>		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) <b>NA</b>		28b. TIME OF INJURY <b>NA</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <b>XX NO</b>	
		28d. DESCRIBE HOW INJURY OCCURRED <b>NA</b>		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>NA</b>		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>NA</b>	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>VID</i>				29c. LICENSE NUMBER <b>D42019</b>		29d. DATE SIGNED (Month, Day, Year) <b>Dec 21 1998</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) <b>JOHN J. CAVER</b>							
31. DATE FILED (Month, Day, Year) <b>DEC 21 1998</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



2000-10-10

10

10

1000 1 3 330

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41097

4 0/4

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ALONZO DOSWELL

2. Date of Death

Month Day Year  
12 17 98

3. Time of Death

3:35 PM

4a. Facility Name (If not institution, give street and number)

WASHINGTON ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

TAKOMA PARK

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

577-70-7134

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

45 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
07/07/53

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince Georges

10c. City, Town or Location

Hyattsville

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

5465 16th Avenue

10f. Zip Code

20782

10g. Citizen of What Country?

United States

11. Marital Status

☒ Never Married ☐ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12College (1-4 or 5+)  
2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Driver

16b. Kind of Business/Industry

Government

17. Father's Name (First, Middle, Last)

Kermit Doswell

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Pride

19a. Informant's Name/Relationship (Type, Print)

Margaret Doswell / Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5323 Chillum Place, N.E. Washington, D.C. 20011

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

FT. LINCOLN CEM.

Date

12/22/98 BRENTWOOD MD.

21. Signature of Funeral Service Licensee



M859

22. Name and Address of Facility

ALEXANDER S. POPE FUNERAL HOMES  
2617 Pennsylvania Avenue, SE DC 20020

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Hemorrhage, INTRA CEREBRAL  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus

Substance Abuse

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

26. Place of Death (Check only one)

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Suicide  
☐ Homicide ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier



29c. License number

14507 D

29d. Date signed (Month, Day, Year)

12/17/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert Gerwin MD 7830 Old Georgetown RD Bethesda MD 20814

31. Date filed (Month, Day, Year)

DEC 21 1998

32. Registrar's Signature



Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4

State  
Registrar

DEC 8 1980

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 41098

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last) SYLVIA M. DANIELS  
2. Date of Death Month Day Year December 18, 1998  
3. Time of Death 1:50 A.M.

Funeral  
Director

4a. Facility Name (If not institution, give street and number) 7812 Karla Lane  
4b. City, Town, or Location of Death Ft. Washington  
4c. County of Death Prince Georges  
5. Social Security Number 212-46-0861  
6. Sex ☐ M ☒ F  
7. Age (In yrs. last birthday) 54 Yrs.  
8. Date of Birth (Month, Day, Year) JAN 9, 1944  
9. Birthplace (State or Foreign Country) Wash., D.C.

Usual Residence of Decedent  
10a. State Maryland  
10b. County Prince Georges  
10c. City, Town or Location Ft. Washington  
10d. Inside City Limits ☒ Yes ☐ No

10e. Street and Number 7812 Karla Lane  
10f. Zip Code 20744  
10g. Citizen of What Country? United States

11. Marital Status ☐ Never Married ☒ Married ☐ Widowed ☐ Divorced  
12. Was Decedent Ever in U.S. Armed Forces? ☐ Yes ☒ No  
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ Yes ☒ No  
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collage (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Pay roll Clerk  
16b. Kind of Business/Industry Government

17. Father's Name (First, Middle, Last) Theodore L. Miles  
18. Mother's Name (First, Middle, Maiden Surname) Arline Wise

19a. Informant's Name/Relationship (Type, Print) Royce G. Daniels / Husband  
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7812 Karla Lane, Ft. Washington, Md. 20744

20a. Method of Disposition ☐ Burial ☒ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)  
20b. Place of Disposition (Name of cemetery, crematory or other place) METROPOLITAN CREMATORY  
20c. Location - City or Town, State 12/22/98 ALEXANDRIA, VIRGINIA

21. Signature of Funeral Service Licensee *Alfred S. Pope* M859  
22. Name and Address of Facility ALEXANDER S. POPE FUNERAL HOMES  
2617 Pennsylvania Avenue, SE DC 20020

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  
Immediate Cause (Final disease or condition resulting in death) a. Metastatic breast carcinoma  
Due to (or as a consequence of):  
Approximate Interval Between Onset and Death 2 years

Sequentially list conditions, if any, leading to immediate cause. Enter underlying cause (Disease or injury that initiated events resulting in death) Last  
b. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  
23b. Did tobacco use contribute to the cause of death?  
1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No  
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? ☐ Yes ☒ No  
26. Place of Death (Check only one)  
Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA  
Other: ☒ Nursing Home ☐ Residence ☐ Other (Specify)  
27. Manner of Death ☒ Natural ☐ Accident ☐ Suicide ☐ Homicide  
28a. Date of Injury (Month, Day Year)  
28b. Time of Injury M  
28c. Injury at Work? ☐ Yes ☒ No  
28d. Describe how injury occurred  
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) ☒ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
29b. Signature and title of certifier *Matilda H. So, MD*  
29c. License number D26250  
29d. Date signed (Month, Day, Year) 12-21-1998

30. Name and address of person who completed cause of death (Item 23e) (Type, Print) MATILDA H. SO 10810 CONNECTICUT AVE, KENSINGTON, MD 20895.  
31. Date filed (Month, Day, Year) DEC 23 1998  
32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41099

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last)

Herman Soogrim DeFreitas

2. Date of Death

Month Day Year  
DECEMBER 20 1998

3. Time of Death

09:18 PM

4a. Facility Name (If not institution, give street and number)

PRINCE GEORGES HOSPITAL CENTER

4b. City, Town, or Location of Death

CHEVERLY

4c. County of Death

PRINCE GEORGES

5. Social Security Number

578-98-9585

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

59 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
December 5, 1939

9. Birthplace (State or Foreign Country)

Guyana, S. America

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Cheverly

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

1807 62nd Avenue

10f. Zip Code

20785

10g. Citizen of What Country?

Guyana, South America

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:  
Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Mechanic

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Norman Persaud

18. Mother's Name (First, Middle, Maiden Surname)

Stella DeFreitas

19a. Informant's Name/Relationship (Type, Print)

Doreen DeFreitas/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1807 62nd Avenue, Cheverly, Maryland 20785

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Harmony Memorial Park

Date

12/24 1998

20c. Location - City or Town, State

Landover, Maryland

21. Signature of Funeral Service Licensee

Nancy A. Perentis

22. Name and Address of Facility

J.B.Jenkins Funeral Home  
7474 Landover Road, Landover, Maryland 20785

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☒ Yes ☐ No

Hospital:

☐ Inpatient ☐ ER/Outpatient ☒ DOA

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Mario F. Golie Jr MD

29c. License number

D33954

29d. Date signed (Month, Day, Year)

DECEMBER 21, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARIO F. GOLIE JR MD 3001 HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785

31. Date filed (Month, Day, Year)

DEC 23 1998

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

11/2/54



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41100

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MARGARET ELIZABETH EDGE</b>				2. Date of Death Month <b>December</b> Day <b>27</b> Year <b>1998</b>		3. Time of Death <b>3:28 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>414 Camden Court</b>				4b. City, Town, or Location of Death <b>Salisbury</b>		4c. County of Death <b>Wicomico</b>		
Funeral Director	5. Social Security Number <b>212-12-2349</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>84</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>June 26, 1914</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent								
10a. State <b>Maryland</b>		10b. County <b>Wicomico</b>		10c. City, Town or Location <b>Salisbury</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>414 Camden Court</b>				10f. Zip Code <b>21801</b>		10g. Citizen of What Country? <b>USA</b>			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>2</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Secretary</b>			16b. Kind of Business/Industry <b>Safemasters</b>		
17. Father's Name (First, Middle, Last) <b>James Diggs</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Elizabeth Ritterbusch</b>				
19a. Informant's Name/Relationship (Type, Print) <b>James Bertram Edge/Son</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P.O. Box 667, Salisbury, MD 21803</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Oak Lawn Cemetery</b>			20c. Location - City or Town, State <b>12/30/98 Baltimore, MD</b>			
21. Signature of Funeral Service Licensee <i>Michael A Dean</i>					22. Name and Address of Facility <b>Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. CARDIOVASCULAR COLLAPSE</b> Due to (or as a consequence of): <b>b. CACHEXIA</b> Due to (or as a consequence of): <b>c. MALNUTRITION</b> Due to (or as a consequence of): <b>d. SENILE DEMENTIA</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death <b>MINS</b> <b>MOS</b> <b>MOS</b> <b>YRS</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Recent past PNEUMONIA</b> <b>CHRONIC COLICULOS, LEB</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29b. Signature and title of certifier <i>Frank W. Colligan MD</i>				29c. License number <b>D0004366</b>		29d. Date signed (Month, Day, Year) <b>12/28/98</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>FRANK W. COLLIGAN MD</b>				<b>540 RIVERSIDE DR SALISBURY, MD 21801</b>					
31. Date filed (Month, Day, Year) <b>DEC 28 1998</b>				32. Registrar's Signature <i>Anna B Sparks</i>					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Amended # 206  
Allegany County 12/30/98

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41101

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

NOLA MARIE ELLIOTT

2. Date of Death

Month  
DECEMBER

Day  
25, 1998

3. Time of Death

4:50 AM

4a. Facility Name (If not institution, give street and number)

ALLEGANY COUNTY NURSING HOME

4b. City, Town, or Location of Death

CUMBERLAND

4c. County of Death

ALLEGANY

Funeral  
Director

5. Social Security Number

213-22-4533

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

94 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
MAR. 16, 1904

9. Birthplace (State or Foreign Country)

WEST VIRGINIA

Usual Residence of Decedent

10a. State

MD

10b. County

ALLEGANY

10c. City, Town or Location

CUMBERLAND

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

510 WELCH AVENUE

10f. Zip Code

21502

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

HOME

17. Father's Name (First, Middle, Last)

ELIJAH VANCE

18. Mother's Name (First, Middle, Maiden Surname)

PHOEBE JANE MORRAL

19a. Informant's Name/Relationship (Type, Print)

OWEN J. RICE / SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

510 WELCH AVENUE, CUMBERLAND, MD 21502

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ZION MEMORIAL PARK

Date

12/25/98

20c. Location - City or Town, State

CUMBERLAND, MD

21. Signature of Funeral Service Licensee

*Donald A. Epchance*

22. Name and Address of Facility

UPCHURCH FUNERAL HOME, P.A.

202 GREENE ST., CUMBERLAND, MD 21502

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CHRONIC OBSTRUCTIVE LUNG DISEASE

2 YRS.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accidental 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*Robustiano J. Barrera, Jr.*

29c. License number

D-14865

29d. Date signed (Month, Day, Year)

DEC 29, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROBUSTIANO J. BARRERA, JR MD. 21502

31. Date filed (Month, Day, Year)

DEC 30 1998

32. Registrar's Signature

*Barrera B. Barrera*

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

50 41102

8 1/7

Reg. No.

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>MILDRED EVERETTE</b>				2. Date of Death Month Day Year <b>December 16, 1998</b>		3. Time of Death <b>4:45 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>3512 Hepburn Court</b>				4b. City, Town, or Location of Death <b>Burtonsville</b>		4c. County of Death <b>Montgomery</b>	
<b>Funeral Director</b>	5. Social Security Number <b>240-12-5756</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>84</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Aug 24, 1914</b>	
	9. Birthplace (State or Foreign Country) <b>North CAROLINA</b>							
<b>To Be Completed by Funeral Director</b>	Usual Residence of Decedent							
	10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Burtonsville</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number <b>3512 Hepburn Court</b>				10f. Zip Code <b>20866</b>		10g. Citizen of What Country? <b>United States</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>COSMETOLOGIST</b>		16b. Kind of Business/Industry <b>BEAUTY SALON</b>			
	17. Father's Name (First, Middle, Last) <b>MARION HALL</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>SALLIE FLOYD</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>GAIL ROBINSON /Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3512 Hepburn Court, Burtonsville, Md. 20866</b>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Lightner Funeral Home</b>		Date <b>Dec 21, 98</b>		20c. Location - City or Town, State <b>Goldsboro, No.Car.</b>	
	21. Signature of Funeral Service Licensee 		M859		22. Name and Address of Facility <b>ALEXANDER S. POPE FUNERAL HOMES 2617 Pennsylvania Avenue, SE DC 20020</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. <b>Renal Failure</b></p> <p>b. <b>Diabetes Mellitus</b></p> <p>c. </p> <p>d. </p> </div> <div style="width: 15%; text-align: center;"> <p>Due to (or as a consequence of):</p> <p>Due to (or as a consequence of):</p> <p>Due to (or as a consequence of):</p> <p>Due to (or as a consequence of):</p> </div> </div> <p>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p>							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Multi-infarct Dementia.</b> <b>Hypertension</b> <b>Anemia</b>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how Injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>D30361</b>		29d. Date signed (Month, Day, Year) <b>December 17, 1998</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Margery G. Myers, MD Walter Reed Army Medical Center Washington, DC 20315</b>								
31. Date filed (Month, Day, Year) <b>DEC 21 1998</b>				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or item 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

**State  
Registrar**





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41103

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>DOROTHY E. FLORIN</b>				2. Date of Death Month <b>DECEMBER</b> Day <b>25</b> Year <b>1998</b>		3. Time of Death <b>2:10 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Berlin Nursing &amp; Rehabilitation Center</b>				4b. City, Town, or Location of Death <b>Berlin</b>		4c. County of Death <b>Worcester</b>	
Funeral Director	5. Social Security Number <b>100-22-9628</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>82</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Feb. 25, 1916</b>	9. Birthplace (State or Foreign Country) <b>New Jersey</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Somerset</b>		10c. City, Town or Location <b>Dames Quarters</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>11359 Hudson White Road</b>				10f. Zip Code <b>21821</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Wife/Mother</b>			16b. Kind of Business/Industry <b>Homemaker</b>	
17. Father's Name (First, Middle, Last) <b>James Fye</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Elizabeth Chamberlin</b>			
19a. Informant's Name/Relationship (Type, Print) <b>William Florin</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Palisabe St. Dobbs Ferry, NY 10522</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Fountain Hill Cemetery</b>		Date <b>12/28/98</b>		20c. Location - City or Town, State <b>Deep River, CT</b>	
21. Signature of Funeral Service Licensee <i>[Signature]</i>					22. Name and Address of Facility <b>108 William St. Burbage Funeral Home Berlin, MD 21811</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heat stroke. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>End Stage Vascular Dementia</b> Due to (or as a consequence of): <b>Multiple Cerebral Infarcts</b> Due to (or as a consequence of): <b>Advanced Cerebrovascular Disease</b> Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Parkinson's Disease</b> <b>Rheumatoid Arthritis</b>								Approximate Interval Between Onset and Death <b>2 yrs</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Parkinson's Disease</b> <b>Rheumatoid Arthritis</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <i>[Signature]</i> <b>Gregorio M. Bellosa M.D.</b>					29c. License number <b>D 29505</b>		29d. Date signed (Month, Day, Year) <b>12-25-98</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>GREGORIO M. BELLOSO, M.D. 5302 CHINABERRY DRIVE, SALISBURY, MD 21801</b>								
31. Date filed (Month, Day, Year) <b>DEC 28 1998</b>			32. Registrar's Signature <i>[Signature]</i> <b>B. Sparks</b>					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

3

State  
Registrar



*[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]*

*[Handwritten signature or initials.]*

98-42-24

to the Hon. Sec. of the Interior

Washington, D.C.

Enclosed for the Bureau are two copies of a report of the

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41104

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>John H. Flett, III</b>				2. Date of Death Month Day Year <b>Dec 18, 1998</b>		3. Time of Death <b>12:15 PM</b>	
	4e. Facility Name (If not institution, give street and number) <b>Southern Maryland Hospital</b>				4b. City, Town, or Location of Death <b>Clinton</b>		4c. County of Death <b>Prince George's</b>	
Funeral Director	5. Social Security Number <b>213 42 6510</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>59</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Sept 8, 1939</b>	
	9. Birthplace (State or Foreign Country) <b>Washington DC</b>		10a. State <b>MD</b>		10b. County <b>P.G.</b>		10c. City, Town or Location <b>Upper Marlboro</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>9910 Lyndie Lane</b>		10f. Zip Code <b>20772</b>		10g. Citizen of What Country? <b>United States</b>	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8th</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>None/ Disabled</b>		16b. Kind of Business/Industry <b>N/A</b>			
	17. Father's Name (First, Middle, Last) <b>John H. Flett</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Rosalie T. King</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Rosalie Flett (MOTHER)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10911 Wharton Drive, Upper Marlboro, Md 20772</b>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Dec 21, 1998 Lee Crematory</b>		20c. Location - City or Town, State <b>Clinton, Maryland</b>			
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>HEMIPLEGIA</b> Due to (or as a consequence of): <b>MULTIPLE INTRACEREBRAL HAEMORRHAGE</b> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>POLYCYTHEMIA</b>		Approximate Interval Between Onset and Death <b>5 DAYS</b> <b>5 DAYS</b>					
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>POLYCYTHEMIA</b>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number <b>D 50653</b>		29d. Date signed (Month, Day, Year) <b>12-18-98</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>GYAN CHAND SURANA 7501 SURRATTS ROAD CLINTON, M.D.</b>								
31. Date filed (Month, Day, Year) <b>DEC 22 1998</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 41105

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>THOMAS LEONARD FORD, Jr.</b>				2. Date of Death Month Day Year <b>December 14, 1998</b>		3. Time of Death <b>12:47 P.M.</b>		
	4a. Facility Name (If not institution, give street and number) <b>Calvert Memorial Hospital</b>				4b. City, Town, or Location of Death <b>Prince Frederick</b>		4c. County of Death <b>Calvert</b>		
Funeral Director	5. Social Security Number <b>219 26 9868</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>59</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Jan 17, 1939</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent								
10a. State <b>Maryland</b>		10b. County <b>Calvert</b>		10c. City, Town or Location <b>Owings</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>143 West Mt. Harmony Road</b>				10f. Zip Code <b>20736</b>		10g. Citizen of What Country? <b>USA</b>			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1961-65</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>white</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>electronics technician</b>			16b. Kind of Business/Industry <b>Dept. of Defense Federal Govt.</b>		
17. Father's Name (First, Middle, Last) <b>Thomas Leonard Ford, Sr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Annie Virginia Johnson</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Alma King Ford / wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P.O. Box 572, Owings, MD 20736</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mt. Harmony Church Cem.</b>			Date <b>12-18-98</b>		20c. Location - City or Town, State <b>Owings, MD</b>		
21. Signature of Funeral Service Licensee <b>William R. Goss</b>				22. Name and Address of Facility <b>Rausch Funeral Home, P.A., Owings, MD 20736</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Arteriosclerotic Cardiovascular Disease</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>								Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier <b>Dr. [Signature]</b>				29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>December 15, 1998</b>			
30. Name and address of person who completed cause of death (from 23a) (Type, Print) <b>J. [Signature] 111 Penn Street, Baltimore, Maryland 21201</b>									
31. Date filed (Month, Day, Year) <b>DEC 17 1998</b>		32. Registrar's Signature <b>[Signature]</b>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28d show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41106

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last) <b>Lydia Fuller</b>				2. Date of Death Month Day Year <b>Dec. 14, 1998</b>				3. Time of Death <b>3:45AM</b>			
4a. Facility Name (If not institution, give street and number) <b>Future Care Pineview Nursing Home</b>				4b. City, Town, or Location of Death <b>Clinton</b>				4c. County of Death <b>Prince Georges</b>			
5. Social Security Number <b>579 28 5885</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>80</b>		8. Date of Birth (Month, Day, Year) <b>July 15, 1918</b>		9. Birthplace (State or Foreign Country) <b>Virginia</b>			
10a. State <b>MD</b>				10b. County <b>P.G..</b>				10c. City, Town or Location <b>Clinton</b>			
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number <b>8600 Mike Shapiro Drive</b>				10f. Zip Code <b>20735</b>			
10g. Citizen of What Country? <b>United States</b>				11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>				15. Decedent's Education (Specify only highest grade completed) <b>8th</b>			
16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Housewife</b>				17. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Housewife</b>				18. Kind of Business/Industry <b>Own Home</b>			
19. Informant's Name/Relationship (Type, Print) <b>Linda Fuller (Daughter)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>18964 Grotto Lane, Germantown, Maryland 20874</b>				20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735</b>				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>RENAL FAILURE - UREMIA DAYS</b> Due to (or as a consequence of): <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE YEARS</b> Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):			
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			
28a. Date of injury (Month, Day Year)				28b. Time of Injury <b>M</b>				28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 				29c. License number <b>D-18545</b>			
29d. Date signed (Month, Day, Year) <b>DECEMBER 15, 1998</b>				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>P. WISOTZKY MD 12070 OLD LINE CENTER WASHINGTON, MD. 20002</b>				31. Date filed (Month, Day, Year) <b>DEC 17 1998</b>			
32. Registrar's Signature 				33. Registrar's Name <b>G. Sparks</b>				34. Registrar's Title <b>Registrar</b>			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit card.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 41107

Certificate of Death

Reg. No.

Physician (Medical Examiner)	1. Decedent's Name (First, Middle, Last) <b>WILLIE JOE FARRIS</b>				2. Date of Death Month Day Year <b>December 18, 1998</b>		3. Time of Death <b>11:50 p.m.</b>		
	4a. Facility Name (If not institution, give street and number) <b>FORT WASHINGTON HOSPITAL</b>				4b. City, Town, or Location of Death <b>FT. WASHINGTON</b>		4c. County of Death <b>PRINCE GEORGE'S</b>		
Funeral Director	5. Social Security Number <b>419-60-4283</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>51 Yrs.</b>		8. Date of Birth (Month, Day, Year) <b>APRIL 18, 1947</b>		
	9. Birthplace (State or Foreign Country) <b>DOLOMITE, AL</b>		10a. State <b>MARYLAND</b>		10b. County <b>PRINCE GEORGE'S</b>		10c. City, Town or Location <b>FT. WASHINGTON</b>		
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>9516 FORT FOOTE RD.</b>		10f. Zip Code <b>20744</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>2 YRS.</b>		18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>DIRECTOR OF FOOD SERVICES</b>		16b. Kind of Business/Industry <b>MARRIOTT CORP -PVT.</b>					
17. Father's Name (First, Middle, Last) <b>LUCIOUS MEALING</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>ERNESTINE MALONE</b>					
19a. Informant's Name/Relationship (Type, Print) <b>BARBARA H. FARRIS</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9516 FORT FOOTE RD. FT. WASHINGTON, MD 20744</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>FT. LINCOLN CEMETERY</b>		Date <b>12-23-98</b>		20c. Location - City or Town, State <b>BRENTWOOD, MD</b>			
21. Signature of Funeral Service Licensee <i>Shawara A. Braxton</i>				22. Name and Address of Facility <b>MARSHALL'S FUNERAL HOME OF MD</b> <b>4308 SUITLAND RD. SUITLAND, MD 20746</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  e. <b>Glioblastoma</b> Due to (or as a consequence of):  f. Due to (or as a consequence of):  g. Due to (or as a consequence of):  h. Due to (or as a consequence of):								Approximate Interval Between Onset and Death <b>6 months</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		26. Place of Death (Check only one) Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Deborah M. Thompson MD</i>		29c. License number <b>D30296</b>		29d. Date signed (Month, Day, Year) <b>12/21/98</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DEBORAH M. THOMPSON MD MARLOW HTS, MD</b>									
31. Date filed (Month, Day, Year) <b>DEC 21 1998</b>		32. Registrar's Signature <i>[Signature]</i>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
(Medical  
Examiner)

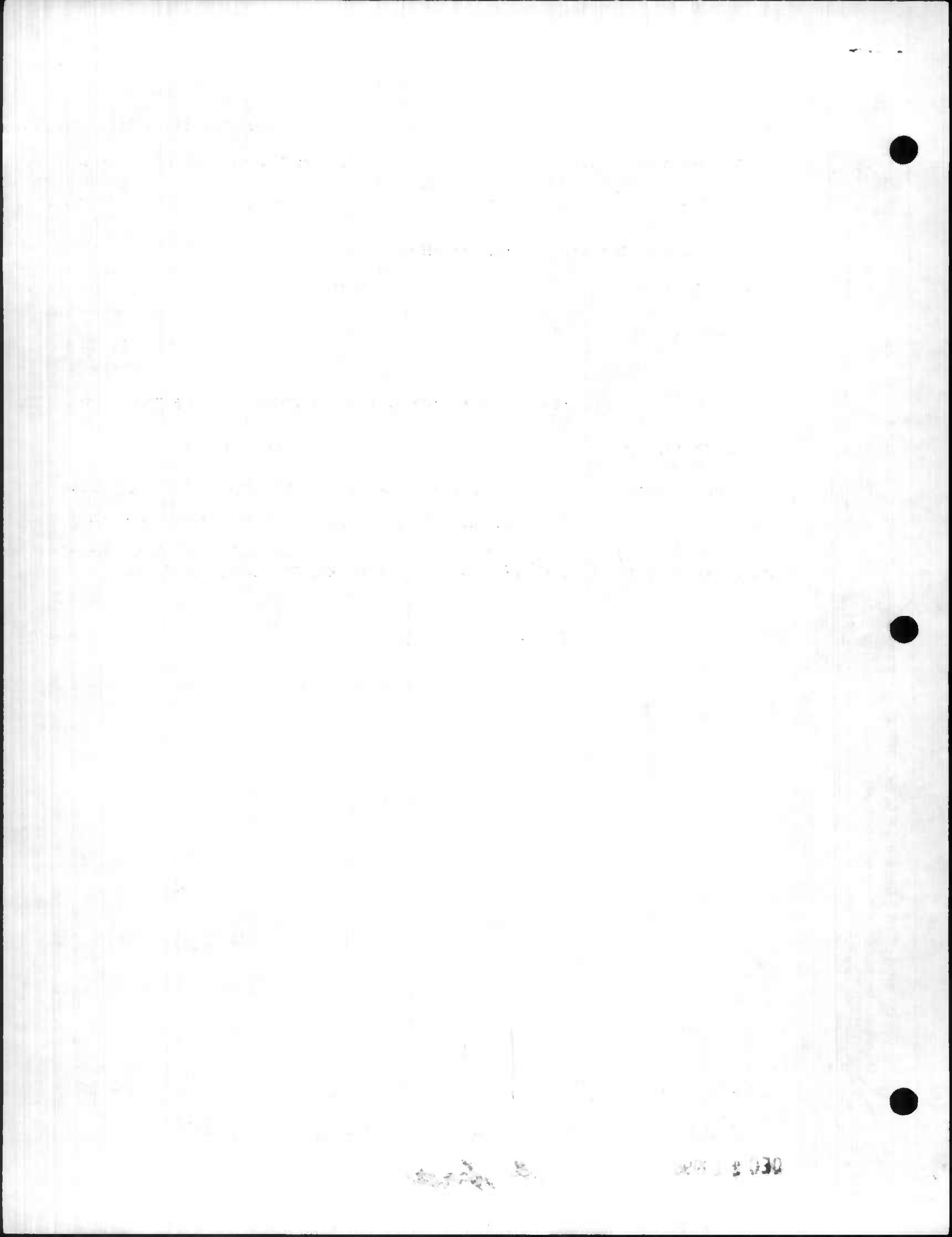
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 41108  
Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Commodore Edward Giffin

2. Date of Death

Month Day Year  
DEC 27 98

3. Time of Death

0338

4a. Facility Name (If not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

Funeral  
Director

5. Social Security Number

220-18-3390

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

71 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
April 30, 1928

9. Birthplace (State or Foreign Country)

Dargan Maryland

Usual Residence of Decedent

10a. State

West Virginia Berkeley

10b. County

10c. City, Town or Location

Falling Waters

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1003 Williams Drive

10f. Zip Code

25419

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)  
10

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

School Bus Contractor

16b. Kind of Business/Industry

Self Employed

17. Father's Name (First, Middle, Last)

Theodore Thomas Giffin

18. Mother's Name (First, Middle, Maiden Surname)

Glendora Virginia Myers

19a. Informant's Name/Relationship (Type, Print)

Ardella Giffin (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1003 Williams Drive Falling Waters WV 25419

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Mountain View Cemetery

Date

12-30-98

20c. Location - City or Town, State

Sharpsburg, Maryland

21. Signature of Funeral Service Licensee

*[Signature]*

22. Name and Address of Facility

Osborne Funeral Home 425 South Conococheague St.  
Williamsport, Maryland 21795

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.

Immediate Cause (Final  
disease or condition  
resulting in death)

a. *Cardiac arrhythmias*

Due to (or as a consequence of):

b. *Pulmonary Fibrosis*

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

c. \_\_\_\_\_  
Due to (or as a consequence of):

d. \_\_\_\_\_  
Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

*Days*

*years*

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy  
performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings  
available prior to  
completion of cause  
of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical  
examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

28. Place of Death (Check only one)

4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury  
(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)

29a. Certifier  
(Check only  
one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

*[Signature]* JAC-4

29c. License number

22457

29d. Date signed (Month, Day, Year)

12/27/98

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

ABOUL WAHED MD 12821 OAK HILL AVE. HAGERSTOWN, MD 21792

State  
Registrar

31. Date filed (Month, Day, Year)

DEC 28 1998

32. Registrar's Signature

*[Signature]* B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 41109

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Isabel

C.

GUM

2. Date of Death

Dec. 25, 1998

3. Time of Death

4:40PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Salisbury Center; Genesis ElderCare,

4b. City, Town, or Location of Death

Salisbury, Md.

4c. County of Death

Wicomico

5. Social Security Number

030-28-7697

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

10-30-1914

9. Birthplace (State or Foreign Country)

DAGSBORO, DE.

Usual Residence of Decedent

10a. State

DE

10b. County

SUSSEX

10c. City, Town or Location

DAGSBORO

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

MAIN STREET

10f. Zip Code

19939

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

STORE MANAGER

16b. Kind of Business/Industry

CLOTHING

17. Father's Name (First, Middle, Last)

FRANK J. CHANDLER

18. Mother's Name (First, Middle, Maiden Summa)

ANNIE CAREY

19a. Informant's Name/Relationship (Type, Print)

FRANK M. GUM / SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

RT. 2 BOX 46, DELMAR, DELAWARE. 19940

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

COL. ARMWELL LONG CEM

Date

12-28-98

20c. Location - City or Town, State

FRANKFORD, DELAWARE

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

MELSON FUNERAL SERVICES

43 THATCHER STREET, FRANKFORD, DE. 19945

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. *Eupnea*

Due to (or as a consequence of):

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. *Hypoxia encephalopathy*

Due to (or as a consequence of):

c. 

Due to (or as a consequence of):

d. 

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D-29349

29d. Date signed (Month, Day, Year)

12/28/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WILLIAM ROBINS, M.D., 1104 HEALTHWAY DR., SALISBURY, MD. 21804

31. Date filed (Month, Day, Year)

DEC 29 1998

32. Registrar's Signature

*Benjamin B. Sparks*State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28e-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41110

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) James Warren Guy						2. Date of Death Month 12 Day 18 Year 1998		3. Time of Death 4:16 p.m.													
	4a. Facility Name (If not institution, give street and number) St. Mary's Hospital						4b. City, Town, or Location of Death Leonardtwn		4c. County of Death St. Mary's													
Funeral Director	5. Social Security Number 213-14-0302		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 80 Yrs.		8. Date of Birth (Month, Day, Year) January 3, 1918		9. Birthplace (State or Foreign Country) Maryland													
	Usual Residence of Decedent																					
10a. State Maryland		10b. County St. Mary's		10c. City, Town or Location Loveville				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No														
10e. Street and Number 28220 Point Lookout Road				10f. Zip Code 20656		10g. Citizen of What Country? United States																
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White														
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4or 5+) 8				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Operator			16b. Kind of Business/Industry General Store															
17. Father's Name (First, Middle, Last) James Warren Guy, Sr.						18. Mother's Name (First, Middle, Maiden Surname) Estelle Long																
19a. Informant's Name/Relationship (Type, Print) Theresa S. Guy, Wife						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 196, Loveville, Maryland 20656																
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) St. Joseph's Cemetery		Date 12-21-98		20c. Location - City or Town, State Morganza, Maryland														
21. Signature of Funeral Service Licensee <i>Edward N. Brinsfield, JR.</i>				22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, MD 20650																		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																						
<table border="1"> <tr> <td rowspan="4">                 Immediate Cause (Final disease or condition resulting in death)                   Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last             </td> <td>a.</td> <td>CARDIAL ARREST</td> <td>Approximate Interval Between Onset and Death 1 Hr.</td> </tr> <tr> <td>b.</td> <td>Due to (or as a consequence of): Congestive Heart Failure</td> <td>8 Yrs</td> </tr> <tr> <td>c.</td> <td>Due to (or as a consequence of): Hypertension</td> <td>20 Yrs</td> </tr> <tr> <td>d.</td> <td>Due to (or as a consequence of): Chronic Renal Failure</td> <td>6 Yrs</td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	CARDIAL ARREST	Approximate Interval Between Onset and Death 1 Hr.	b.	Due to (or as a consequence of): Congestive Heart Failure	8 Yrs	c.	Due to (or as a consequence of): Hypertension	20 Yrs	d.	Due to (or as a consequence of): Chronic Renal Failure	6 Yrs
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	CARDIAL ARREST	Approximate Interval Between Onset and Death 1 Hr.																			
	b.	Due to (or as a consequence of): Congestive Heart Failure	8 Yrs																			
	c.	Due to (or as a consequence of): Hypertension	20 Yrs																			
	d.	Due to (or as a consequence of): Chronic Renal Failure	6 Yrs																			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Carcinoma Prostate								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown														
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)																		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No														
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)														
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <i>aa. Patil</i>		29c. License number D23634		29d. Date signed (Month, Day, Year) December 21, 1998														
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Adinath Patil Bean Medical Center California, MD 20619																						
31. Date filed (Month, Day, Year) DEC 21 1998				32. Registrar's Signature <i>B. Sparks</i>																		

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

GUY, JAMES

641 UB



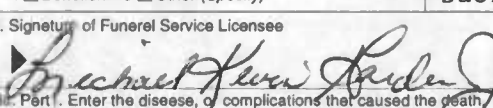
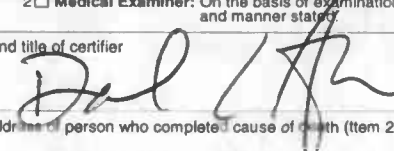


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Anne Ella Gass</b>				2. Date of Death Month <b>December</b> Day <b>26</b> Year <b>1998</b>		3. Time of Death <b>1:30 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>38320 Point Breeze Road</b>				4b. City, Town, or Location of Death <b>Colton Point</b>		4c. County of Death <b>St. Mary's</b>		
Funeral Director	5. Social Security Number <b>219-58-9688</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>69 Yrs.</b>	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>February 6, 1929</b>	9. Birthplace (State or Foreign Country) <b>Washington D.C.</b>	
	Usual Residence of Decedent								
10a. State <b>Maryland</b>		10b. County <b>St. Mary's</b>		10c. City, Town or Location <b>Colton Point</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>38320 Point Breeze Road</b>				10f. Zip Code <b>20626</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>			16b. Kind of Business/Industry <b>Own Home</b>		
17. Father's Name (First, Middle, Last) <b>Thomas F. Kennedy</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Grace Marie Bailey</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Glenn G. Gass/Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P.O. Box 131, Colton Point, MD 20626</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Sacred Heart Cemetery</b>		20c. Location - City or Town, State <b>12/28/98 Bushwood, MD</b>			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, MD 20650</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Metastatic Colon Cancer</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>								Approximate Interval Between Onset and Death <b>1 yr</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
				28d. Describe how Injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 				29c. License number <b>D25230</b>	
				29d. Date signed (Month, Day, Year) <b>12/28/98</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>David Allen, MD Leonardtown, MD 20650</b>									
31. Date filed (Month, Day, Year) <b>DEC 29 1998</b>				32. Registrar's Signature 					

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
 Certificate of Death

Reg. No.

98 41112

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>GORDON B. GRIFFIN</b>				2. Date of Death Month <b>Dec.</b> Day <b>25</b> Year <b>1998</b>		3. Time of Death <b>11:44 am</b>	
	4a. Facility Name (If not institution, give street and number) <b>CUMBERLAND NURSING HOME</b>				4b. City, Town, or Location of Death <b>CUMBERLAND</b>		4c. County of Death <b>ALLEGANY</b>	
Funeral Director	5. Social Security Number <b>214-07-5550</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>85</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Jan 15, 1913</b>	
	9. Birthplace (State or Foreign Country) <b>PA</b>		10a. State <b>MD</b>		10b. County <b>Allegany</b>		10c. City, Town or Location <b>Cumberland</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>523 1/2 E. Oldtown Road</b>		10f. Zip Code <b>21502</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WW II</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Mail Carrier</b>		16b. Kind of Business/Industry <b>U.S. Postal Dept.</b>			
	17. Father's Name (First, Middle, Last) <b>Joseph H. Griffin</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Lillie M. (Teal)</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Theresa Niland--granddaughter</b> <b>Kathleen Niland--granddaughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6821 Kinkade Avenue; Falls Church, VA 22042</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>St. Mary's Cemetery</b>		20c. Location - City or Town, State <b>12/29 Cumberland, MD</b>			
	21. Signature of Funeral Service Licensee <i>Nicholas J. Scarpelli</i>		22. Name and Address of Facility <b>Scarpelli Funeral Home, P.A.</b> <b>Cumberland, MD 21502</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>CVA.</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Dehydration.</b> <b>Organic brain syndrome</b> <b>Parkinson's disease</b>							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred					
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
Medical Certification: To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier <i>Dr. H. H. M. O. S.</i> MD		29c. License number <b>DO 4981</b>		29d. Date signed (Month, Day, Year) <b>December 26, 1998</b>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>P. H. A. L. M. O. S. 302 Schley St. Cumberland, Md 21502</b>							
	31. Date filed (Month, Day, Year) <b>DEC 29 1998</b>		32. Registrar's Signature <i>P. H. A. L. M. O. S.</i>					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41113

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

DELLA IRENE GULICK

2. Date of Death

Month Day Year  
December 22, 1998

3. Time of Death

11:45 PM

4a. Facility Name (If not institution, give street and number)

Memorial Hospital

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

5. Social Security Number

220-10-7537

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
MAY 30, 1920

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

WEST VIRGINIA

10b. County

MINERAL

10c. City, Town or Location

RIDGELEY

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

RT 1 BOX 507A

10f. Zip Code

26753

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

HOUSEWIFE

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

THOMAS HEAPS

18. Mother's Name (First, Middle, Maiden Surname)

LULA BARNES

19a. Informant's Name/Relationship (Type, Print)

SHIRLEY STACHOWIAK/DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

RT 1 BOX 508, RIDGELEY, WV 26753

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

ROCKY GAP VETERANS CEMETERY

Date

DEC. 24, 1998

20c. Location - City or Town, State

FLINTSTONE, MD

21. Signature of Funeral Service Licensee

D Douglas A Hafer

22. Name and Address of Facility

HAFER FUNERAL HOME

1302 NATIONAL HWY, LA VALE, MD 21502

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of death.

Immediate Cause (Final disease or condition resulting in death)

Sepsis

a. Due to (or as a consequence of):

2 WEEKS

b. PERITONITIS  
Due to (or as a consequence of):

2 WEEKS

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. V. Poonai

29c. License number

D36766

29d. Date signed (Month, Day, Year)

December 23 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. V. Poonai, 920 National Hwy, LaVale, MD 21502

31. Date filed (Month, Day, Year)

DEC 24 1998

32. Registrar's Signature

B. Spaul

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

IRENE GULICK 220-10-7537





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 41114

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Isabelle GREEN

2. Date of Death  
Month Day Year  
DECEMBER 18, 19983. Time of Death  
1:45 P.M.

4a. Facility Name (If not institution, give street and number)

SACRED HEART HOSPITAL

4b. City, Town, or Location of Death

CUMBERLAND

4c. County of Death

ALLEGANY

Funeral  
Director

5. Social Security Number

220-16-5916

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

AUGUST 6 1914

9. Birthplace (State or Foreign  
Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ALLEGANY

10c. City, Town or Location

CUMBERLAND

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

500 KINGSLEY PLACE

10f. Zip Code

21502

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?1 ☐ Yes 2 ☒ NoIf Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: BLACK

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

9

College (14 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

HOME MAKER

16b. Kind of Business/Industry

HOME MAKER

17. Father's Name (First, Middle, Last)

JACOB TAYLOR

18. Mother's Name (First, Middle, Maiden Surname)

EDITH TAYLOR

19a. Informant's Name/Relationship (Type, Print)

FAYE COLE DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

69 GREENE STREET CUMBERLAND MARYLAND 21502

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

WOOD LAWN CEMETERY DEC 21 1998

Date

20c. Location - City or Town, State

CUMBERLAND MARYLAND

21. Signature of Funeral Service Licensee

Dale L. Merritt

22. Name and Address of Facility

MERRITT-ADAMS FUNERAL HOME

404 DECATUR STREET CUMBERLAND MARYLAND

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Aspiration Pneumonia - Hypoxemia

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

6 weeks

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Vomiting and aspiration

Due to (or as a consequence of):

4 days

c. Son of Gas Reflex

Due to (or as a consequence of):

1 year

d. Bilateral, Multiple strokes

10 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

Dehydration

Secondary Hyperaldosteronism

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending  
Investigation6 ☐ Could not be  
determined28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Felipa M. Fajardo MD FACP

29c. License number

D 13601

29d. Date signed (Month, Day, Year)

DECEMBER 18, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR V.R. FELIPA 925 BISHOP WALSH DRIVE CUMBERLAND MARYLAND 21502

31. Date filed (Month, Day, Year)

DEC 21 1998

32. Registrar's Signature

Benjamin S. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 41115

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) George Thomas Groom, Sr.				2. Date of Death Month Day Year Dec 15 1998				3. Time of Death 0950 AM	
	4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center				4b. City, Town, or Location of Death Annapolis				4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 220 42 0230		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 55 Yrs.		8. Date of Birth (Month, Day, Year) Aug 20 1943		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent									
10a. State Maryland		10b. County Anne Arundel		10c. City, Town or Location Edgewater				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 3604 Edgemont Street				10f. Zip Code 21037				10g. Citizen of What Country? United States		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: Vietnam		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) manager				16b. Kind of Business/Industry Stidham Tire Co.		
17. Father's Name (First, Middle, Last) John Carlyle Groom, Jr.					18. Mother's Name (First, Middle, Maiden Surname) Catherine Dean					
19a. Informant's Name/Relationship (Type, Print) Mary F. Groom- wife					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) same as #10					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)					20b. Place of Disposition (Name of cemetery, crematory or other place) Solomons UMCemetery Dec 18 1998					
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility Rausch Funeral Home PA 4405 Broomes Is. Rd. Port Republic MD 2067					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. LIVER FAILURE Due to (or as a consequence of):</p> <p>b. ALCOHOLIC CIRRHOSIS Due to (or as a consequence of):</p> <p>c. HEPATORENAL SYNDROME Due to (or as a consequence of):</p> <p>d.</p> </div> <div style="width: 15%; text-align: center;"> <p>Approximate Interval Between Onset and Death</p> <p>2 DAYS</p> <p>10 DAYS</p> <p>1 DAY</p> </div> </div>										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier 					29c. License number MD D39037		29d. Date signed (Month, Day, Year) 12/15/98			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DOUGLASS S. MITCHELL, AAMC, 64 FRANKLIN, ANNAPOLIS MD 21401										
31. Date filed (Month, Day, Year) DEC 17 1998		32. Registrar's Signature 								

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend #26, Residence, 12/17/98, drw

Certificate of Death

Reg. No.

98 41116

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

ROBERT ERROLL GAINES, JR.

2. Date of Death  
Month

Day

Year

DECEMBER

14

1998

3. Time of Death

1404

4a. Facility Name (If not institution, give street and number)

2607 Imperial Court

4b. City, Town, or Location of Death

Dunkirk

4c. County of Death

Calvert

5. Social Security Number

578-40-1402

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

67

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

9/2/31

9. Birthplace (State or Foreign Country)

Wash., D.C.

Usual Residence of Decedent

10a. State

MD

10b. County

Calvert

10c. City, Town or Location

Dunkirk

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

2607 Imperial Court

10f. Zip Code

20754

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes 2 ☐ No

If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

white

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

18e. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

business owner

16b. Kind of Business/Industry

retail sales

17. Father's Name (First, Middle, Last)

Robert Erroll Gaines, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Eleanore B. Miller

19a. Informant's Name/Relationship (Type, Print)

Sharon Gaines/ wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2607 Imperial Court, Dunkirk, MD 20754


20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

So. Memorial Gardens 12/18/98 Dunkirk, MD

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Raymond Funeral Home, P.A.  
P.O. Box 121, Dunkirk, MD 20754

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. RESPIRATORY FAILURE

Due to (or as a consequence of):

b. IDIOPATHIC PULMONARY FIBROSIS

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

9 MONTHS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending Investigation2 ☐ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

 M.D.

29c. License number

D 40370

29d. Date signed (Month, Day, Year)

12/14/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. PETER WISNIEWSKI, M.D. PRINCE FREDERICK, MD 20678

31. Date filed (Month, Day, Year)

DEC 17 1998

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

20





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41117

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CLARENCE

GUEST

2. Date of Death

Month  
DECDay  
22Year  
1998

3. Time of Death

4:13 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

NATIONAL NAVAL MEDICAL CENTER

4b. City, Town, or Location of Death

BETHESDA

4c. County of Death

MONTGOMERY

5. Social Security Number

446-14-3562

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

76 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month, Day, Year  
Sept 19 1922

9. Birthplace (State or Foreign Country)

Enid, Okla.

Usual Residence of Decedent

10a. State  
Maryland10b. County  
Prince George10c. City, Town or Location  
Fort Washington

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4200 Flam Street

10f. Zip Code

20744

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates: 1966-  
197013. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4+

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Associate Professor

16b. Kind of Business/Industry

D.C. Government

17. Father's Name (First, Middle, Last)

Clarence Arnold Guest, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Alta Zephyr Pettie

19a. Informant's Name/Relationship (Type, Print)

Shirley A. Guest (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4200 Flam St., Ft. Washington, Md. 20744

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Arlington National

Date

12/30/98

20c. Location - City or Town, State

Arlington, Va.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility  
Jordan Funeral Service, Inc  
4001 Benning Rd., N.E. (Wash., D.C. 20019)23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

e. INTRACEREBRAL HEMORRHAGE

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury et  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D-0054195 (MD)

29d. Date signed (Month, Day, Year)

22 Dec 98

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

ANNE T. FOX, LT, MC, USNR

NATIONAL NAVAL MEDICAL CENTER

BETHESDA MD 20889-5600

31. Date filed (Month, Day, Year)

DEC 24 1998

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

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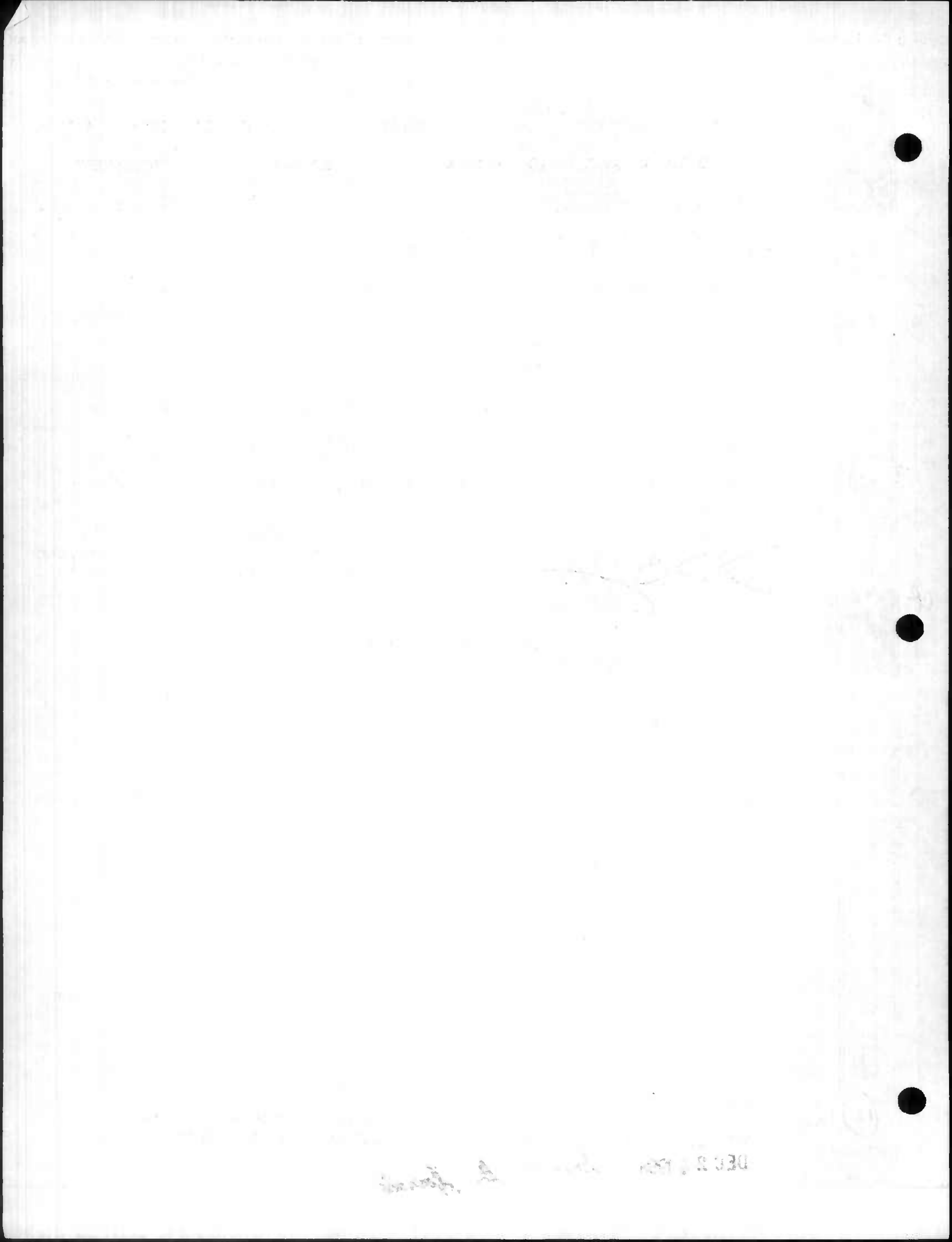
Physician  
/Medical  
Examiner

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.  
State of Maryland / Department of Health and Mental Hygiene  
**Certificate of Death**

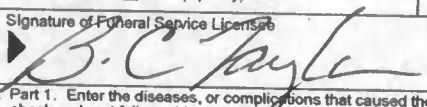
98 41118

Reg. No.

Physician  
/Medical  
Examiner

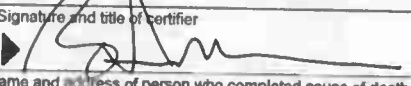

Funeral  
Director

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle Last) <b>LUCIOUS CHARLES GOODIN</b>				2. Date of Death Month Day Year <b>December 16, 1998</b>		3. Time of Death <b>2200</b>	
4a. Facility Name (If not institution, give street and number) <b>10718 Brookwood Avenue</b>				4b. City, Town, or Location of Death <b>Upper Marlboro</b>		4c. County of Death <b>Prince George's</b>	
5. Social Security Number <b>258-50-9473</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>58 Yrs.</b>		8. Date of Birth (Month, Day, Year) <b>Jan 22, 1940</b>	
9. Birthplace (State or Foreign Country) <b>Georgia</b>		10a. State <b>MD</b>		10b. County <b>Prince George's</b>		10c. City, Town or Location <b>Upper Marlboro</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>10718 Brookwood Avenue</b>		10f. Zip Code <b>20772</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+) <b>9</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired.) <b>Welder</b>		16b. Kind of Business/Industry <b>Private Industry</b>			
17. Father's Name (First, Middle, Last) <b>JAMES GOODIN</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>EMMA KELLY</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Darlene Goodin - Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4452 B Street, SE #301, Washington DC 20019</b>			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Chesapeake Crematory</b>		Date <b>Dec 18 1998</b>		20c. Location - City or Town, State <b>Beltsville, MD</b>	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Taylor's Funeral Home 1722 North Capitol Street, NW</b>			

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part 1. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  a. <b>Lung Cancer</b> Due to (or as a consequence of):  b. _____ Due to (or as a consequence of):  c. _____ Due to (or as a consequence of):  d. _____				Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause in Part I.				23b. Did tobacco use contribute to the cause of death? <b>1</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
				24a. Was an autopsy performed? <b>1</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
				24b. Were autopsy findings available prior to completion of cause of death? <b>1</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <b>1</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
		28c. Injury at Work? <b>1</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <b>1</b> <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier  <b>MD</b>		29c. License number <b>D0053219</b>		29d. Date signed (Month, Day, Year) <b>12/18/98</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Zafar Ansari, M.D. 8926 Woodyard Road, Suite 101, Clinton,</b>					
31. Date filed (Month, Day, Year) <b>DEC 21 1998</b>		32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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State  
Registrar

SECRET  
NO FORN DISSEM  
EXCLUDED FROM AUTOMATIC  
DOWNGRADING AND  
DECLASSIFICATION

SECRET  
NO FORN DISSEM  
EXCLUDED FROM AUTOMATIC  
DOWNGRADING AND  
DECLASSIFICATION

~~SECRET~~

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

10 0/10

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CATHERINE OLIVIA GAMBLE

2. Date of Death

Month Day Year  
December 17, 1998

3. Time of Death

7:03 A.M.

4a. Facility Name (If not institution, give street and number)

WASHINGTON ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

TAKOMA PARK

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

579-26-3255

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

74

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
JAN 12, 1924

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

49 Oswego Avenue

10f. Zip Code

20720

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Bleak, White, etc.

Specify: BLACK

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16e. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

House wife

16b. Kind of Business/Industry

Privat Home

17. Father's Name (First, Middle, Last)

GEORGE SHACKLEFORD

18. Mother's Name (First, Middle, Maiden Surname)

LOUISE BROWN

19a. Informant's Name/Relationship (Type, Print)

BEVERLY GAMBLE / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

49 Oswego Avenue, Silver Spring, Md. 20720

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Date

20c. Location - City or Town, State

GATE OF HEAVEN CEMETERY DEC 26, 98 SILVER SPRING, MD.

21. Signature of Funeral Service Licensee

M859

22. Name and Address of Facility

ALEXANDER S. POPE FUNERAL HOMES

2617 Pennsylvania Avenue, SE DC 20020

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

e. Congestive Heart Failure, acute

3 days

Due to (or as a consequence of):

b. Massive Brain Infarction

3 wks

Due to (or as a consequence of):

c. Persistent Vegetative State

3 wks

Due to (or as a consequence of):

d. Diabetes Mellitus, uncontrolled

3 days

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus

Renal Failure

Alzheimer's Disease, advanced

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24e. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

Investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charles L. Franklin Jr. 11120 New Hampshire Ave Silver Spring MD 20904

31. Date filed (Month, Day, Year)

DEC 21 1998

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Sarah Virginia Huffer

2. Date of Death

Month Day Year  
Dec. 28 1998

3. Time of Death

7:55 PM

4a. Facility Name (If not institution, give street and number)

VANTAGE HOUSE

4b. City, Town, or Location of Death

COLUMBIA

4c. County of Death

HOWARD

Funeral  
Director

5. Social Security Number

577-20-4001

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

80

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
SEPT. 2, 1918

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

HOWARD

10c. City, Town or Location

COLUMBIA

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5400 VANTAGE POINT ROAD

10f. Zip Code

21044

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

Collage (1-4 or 5+)

5+

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

PSYCHIATRIST

16b. Kind of Business/Industry

MEDICAL PROFESSION

17. Father's Name (First, Middle, Last)

CLARENCE EDWIN HUFFER

18. Mother's Name (First, Middle, Maiden Surname)

RUTH N. BAKER

19a. Informant's Name/Relationship (Type, Print)

JAMES G. THOMPSON/COUSIN

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. BOX 150, ROHRERSVILLE, MARYLAND 21779

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

BOONSBORO CEMETERY

Date

1/2/99

20c. Location - City or Town, State

BOONSBORO, MARYLAND

21. Signature of Funeral Service

Paul M. Dean

22. Name and Address of Facility

BAST FUNERAL HOME

7606 Old National Pike

Boonsboro, Maryland 21713

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Myelodysplastic syndrome  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death

3 months

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Colon CA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29e. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Pio Poblete MD

29c. License number

D50338

29d. Date signed (Month, Day, Year)

Dec. 28, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Pio L. Poblete MD, 11055 Little Patuxent Parkway, Columbia MD 21044

31. Date filed (Month, Day, Year)

JAN 04 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
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Division of Vital Records, P.O. Box 68760,





Reg. No.

DHMH 16 Rev 6/95



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41122

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ETHEL CODY HENNEBERGER

2. Date of Death

Month Day Year  
December 11, 1998

3. Time of Death

3:22 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

WASHINGTON COUNTY HOSPITAL

4b. City, Town, or Location of Death

HAGERSTOWN

4c. County of Death

WASHINGTON

5. Social Security Number

213-40-6867

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
DEC. 16, 1915

9. Birthplace (State or Foreign Country)

NORTH CAROLINA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

WASHINGTON

10c. City, Town or Location

BOONSBORO

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

108 NORTH MAIN STREET

10f. Zip Code

21713

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

TEACHER

16b. Kind of Business/Industry

PUBLIC SCHOOL SYSTEM

17. Father's Name (First, Middle, Last)

CORTEZ R. CODY

18. Mother's Name (First, Middle, Maiden Summa)

BARBARA SEAGLE

19a. Informant's Name/Relationship (Type, Print)

WILLIAM R. HENNEBERGER/SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

213 DELLA LANE, BOONSBORO, MARYLAND 21713

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

SMITHSBURG CREMATORY

Date

12/12/98

20c. Location - City or Town, State

SMITHSBURG, MARYLAND

21. Signature of Funeral Service Licensee

Paul M. Dean

22. Name and Address of Facility

EAST FUNERAL HOME

7606 Old National Pike

Boonsboro, Maryland 21713

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Hypertrophic Cardiomyopathy

Due to (or as a consequence of):

years

b. Arteriosclerotic Heart Disease

Due to (or as a consequence of):

years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Fracture Right Femur

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

December 2, 1998

28b. Time of Injury

noon M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Fell at a restaurant

28a. Place of Injury - At home, farm, street, factory, office

building, etc. (Specify)

Mt Gate Restaurant, Waynesboro, PA

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

Mountingate Restaurant Waynesboro PA

29a. Certifier

(Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D01062

29d. Date signed (Month, Day, Year)

January 6, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Edward W. Ditto, III, M.D. 217 W. Washington St. Hagerstown, MD 21740

31. Date filed (Month, Day, Year)

JAN 06 1999

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41123

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last) **MARGARET COVINGTON HAWK** 2. Date of Death Month **December** Day **24** Year **1998** 3. Time of Death **0215**

Funeral  
Director

4a. Facility Name (If not institution, give street and number) **Atlantic General Hospital** 4b. City, Town, or Location of Death **Berlin** 4c. County of Death **Worcester**

5. Social Security Number **215-14-3012** 6. Sex **1** ☐ M ☒ F 7. Age (In yrs. last birthday) **80** Yrs. 8. Date of Birth (Month, Day, Year) **November 3, 1918** 9. Birthplace (State or Foreign Country) **Maryland**

Usual Residence of Decedent 10a. State **Maryland** 10b. County **Somerset** 10c. City, Town or Location **Pocomoke** 10d. Inside City Limits ☐ Yes ☒ No

10e. Street and Number **8894 Courthouse Hill Rd** 10f. Zip Code **21851** 10g. Citizen of What Country? **USA**

11. Marital Status **1** ☐ Never Married **2** ☒ Married **3** ☐ Widowed **4** ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? **1** ☐ Yes **2** ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) **1** ☐ Yes **2** ☒ No Specify: 14. Race - American Indian, Black, White, etc. Specify: **White**

15. Decedent's Education (Specify only highest grade completed) **12** 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) **Homemaker** 16b. Kind of Business/Industry **Domestic**

17. Father's Name (First, Middle, Last) **William Wallace Covington** 18. Mother's Name (First, Middle, Maiden Surname) **Mary Hearn Merrill**

19a. Informant's Name/Relationship (Type, Print) **Donald N. Hawk/Husband** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) **8894 Courthouse Hill Rd., Pocomoke, MD 21851**

20a. Method of Disposition **1** ☒ Burial **2** ☐ Cremation **3** ☐ Removal from State **4** ☐ Donation **5** ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) **Salem U.M. Cemetery** Date **12/27/98** 20c. Location - City or Town, State **Pocomoke, MD**

21. Signature of Funeral Service Licensee **Michael A. Dean** 22. Name and Address of Facility **Holloway-Melson Funeral Home P.A. 103 Linden Ave., Pocomoke City, MD 21851**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **a. Leukemia** Due to (or as a consequence of): **b.** Due to (or as a consequence of): **c.** Due to (or as a consequence of): **d.** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last {

Approximate Interval Between Onset and Death **2 months**

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? **1** ☐ Yes **2** ☒ No **3** ☐ Probably **4** ☐ Unknown

24a. Was an autopsy performed? **1** ☐ Yes **2** ☒ No 24b. Were autopsy findings available prior to completion of cause of death? **1** ☐ Yes **2** ☐ No

25. Was case referred to medical examiner? **1** ☐ Yes **2** ☒ No 26. Place of Death (Check only one) Hospital: **1** ☒ Inpatient **2** ☐ ER/Outpatient **3** ☐ DOA Other: **4** ☐ Nursing Home **5** ☐ Residence **6** ☐ Other (Specify)

27. Manner of Death **1** ☐ Natural **5** ☐ Pending investigation **2** ☐ Accident **6** ☐ Could not be determined **3** ☐ Suicide **4** ☐ Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury **M** 28c. Injury at Work? **1** ☐ Yes **2** ☒ No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) **1** ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. **2** ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier **Dr. [Signature]** 29c. License number **D46257** 29d. Date signed (Month, Day, Year) **12/24/98**

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) **9714 Heathway Drive Berlin, MD 21811**

31. Date filed (Month, Day, Year) **DEC 28 1998** 32. Registrar's Signature **[Signature]**

State  
Registrar

Hawk, Margaret 215-14-3012 11/3/18  
Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

0215 12/24/98  
Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director  
To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41124

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ELLEN HUGHES</b>				2. Date of Death Month Day Year <b>December 25, 1998</b>				3. Time of Death <b>9:00 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Wicomico Nursing Home</b>				4b. City, Town, or Location of Death <b>Salisbury</b>				4c. County of Death <b>Wicomico</b>	
Funeral Director	5. Social Security Number <b>220-34-9311</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>95</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>10/14/1903</b>		9. Birthplace (State or Foreign) <b>Penn.</b>	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <b>Md</b>		10b. County <b>Wicomico</b>		10c. City, Town or Location <b>Salisbury, Maryland</b>				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number <b>28605 Old Quantico Road</b>				10f. Zip Code <b>21801</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Home Maker</b>			16b. Kind of Business/Industry <b>Own Home</b>			
	17. Father's Name (First, Middle, Last) <b>Warren Murray Britton</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Jennie Schnee</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Hobart Hughes, Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5522 Woodbine Lane, Salisbury, Md.</b>					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Parsons Cemetery</b>		Date <b>12/30</b>		20c. Location - City or Town, State <b>Salisbury, Md.</b>			
	21. Signature of Funeral Service Licensee <i>[Signature]</i> <b>MOO-417</b>		22. Name and Address of Facility <b>Messick Funeral Home, P.O. Box 61 Bivalve, Maryland 21814</b>							
	23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Acute CVA @ Left Hemiparesis 28 days</b> Due to (or as a consequence of): <b>b. Right Middle Cerebral Artery Occlusion</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Chronic Atrial Fibrillation</b> <b>Chronic Congestive Heart Failure</b>									
Physician /Medical Examiner	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred	
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
State Registrar	29b. Signature and title of certifier <i>[Signature]</i> <b>D29505</b>				29c. License number <b>12-26-98</b>		29d. Date signed (Month, Day, Year)			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>GREGORIO M. BELLOSO, M.D. 5302 CHINABERRY DRIVE, SALISBURY, MD 21801</b>									
31. Date filed (Month, Day, Year) <b>DEC 28 1998</b>		32. Registrar's Signature <i>[Signature]</i>								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41125

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MARY LOUISE HOUSER</b>				2. Date of Death Month Day Year <b>DEC. 23, 1998</b>		3. Time of Death <b>7:50 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>CONVALESCENT WESTMINSTER NURSING AND CENTER</b>				4b. City, Town, or Location of Death <b>WESTMINSTER</b>		4c. County of Death <b>CARROLL</b>	
Funeral Director	5. Social Security Number <b>448-36-7832</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>98</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>MAR. 16, 1900</b>	
	9. Birthplace (State or Foreign Country) <b>Indiana</b>		10a. State <b>MD</b>		10b. County <b>Carroll</b>		10c. City, Town or Location <b>Westminster</b>	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number <b>445 Pleasanton Rd. #33</b>		10f. Zip Code <b>21157</b>		10g. Citizen of What Country? <b>United States</b>	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Domestic</b>			
	17. Father's Name (First, Middle, Last) <b>David Gordon Cummins</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Lillie Koch</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Ellouise Barnes/daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>445 Pleasanton Rd. #33, Westminster MD 21157</b>			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Lorraine Park Cem.</b>		20c. Date <b>12/28/98</b>		20d. Location - City or Town, State <b>Baltimore, MD</b>	
	21. Signature of Funeral Service Licensee <i>Jennifer L. Schen</i>				22. Name and Address of Facility <b>91 Willis Street Myers Funeral Home Westminster, MD 21157</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Pneumonia</b> Due to (or as a consequence of): b. <b>HPTN</b> Due to (or as a consequence of): c. <b>Dementia</b> Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated event resulting in death) Last  Approximate Interval Between Onset and Death <b>2 wks</b> <b>15 yrs</b> <b>7 yr</b>							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28e. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred					
	28f. Location (Street and Number or Rural Route Number, City or Town, State)		29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
	29b. Signature and title of certifier <i>J. Middleton</i>		29c. License number <b>D25443</b>		29d. Date signed (Month, Day, Year) <b>12-24-98</b>			
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>John Middleton 688 Poole Road Westminster, MD 21157</b>							
	31. Date filed (Month, Day, Year) <b>DEC 28 1998</b>		32. Registrar's Signature <i>P. Sparks</i>					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 41126

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ALICE HOHMES</b>				2. Date of Death Month Day Year <b>DECEMBER 17, 98</b>		3. Time of Death <b>2:00 PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>NORTHWEST HOSPITAL CENTER</b>				4b. City, Town, or Location of Death <b>RANDALLSTOWN</b>		4c. County of Death <b>BALTIMORE</b>		
Funeral Director	5. Social Security Number <b>579-36-9189</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>93</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Sept 12 1905</b>		
	9. Birthplace (State or Foreign Country) <b>Indiana</b>		10a. State <b>Md</b>		10b. County <b>Carroll</b>		10c. City, Town or Location <b>Sykesville</b>		
Usual Residence of Decedent									
10d. Inade City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number <b>2306 Lake Circle Drive</b>		10f. Zip Code <b>21784</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			
14. Race - American Indian, Black, White, etc. Specify: <b>white</b>			15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) <b>+2</b>			16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>executive secretary</b>			
16b. Kind of Business/Industry <b>U.S. Government</b>			17. Father's Name (First, Middle, Last) <b>Harry Lee Burns</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Nettie L. Conrad</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Shar Hohmes (daughter-in-law)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2306 Lake Circle Dr., Sykesville, MD 21784</b>					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Cedar Hill Cemetery</b>		Date <b>12/21/98</b>		20c. Location - City or Town, State <b>Suitland, Md.</b>	
21. Signature of Funeral Service Licensee <b>► Paige Haight Herbert</b>				22. Name and Address of Facility <b>Haight Funeral Home &amp; Chapel P.O. Box 195 Sykesville, MD 21784</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. CONGESTIVE CARDIOMYOPATHY</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. _____</b> Due to (or as a consequence of): <b>c. _____</b> Due to (or as a consequence of): <b>d. _____</b>									
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown									
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DEMENTIA</b> <b>RENAL INSUFFICIENCY</b>									
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28d. Describe how injury occurred				28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)					
28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier <b>► K.S. RAO, M.D.</b>				29c. License number <b>D 43462</b>		29d. Date signed (Month, Day, Year) <b>DECEMBER 17, 98</b>			
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) <b>K.S. RAO, M.D. NORTHWEST HOSPITAL CENTER, RANDALLSTOWN, MD</b>									
31. Date filed (Month, Day, Year) <b>DEC 22 1998</b>				32. Registrar's Signature <b>► Geneva B. Sparks</b>					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

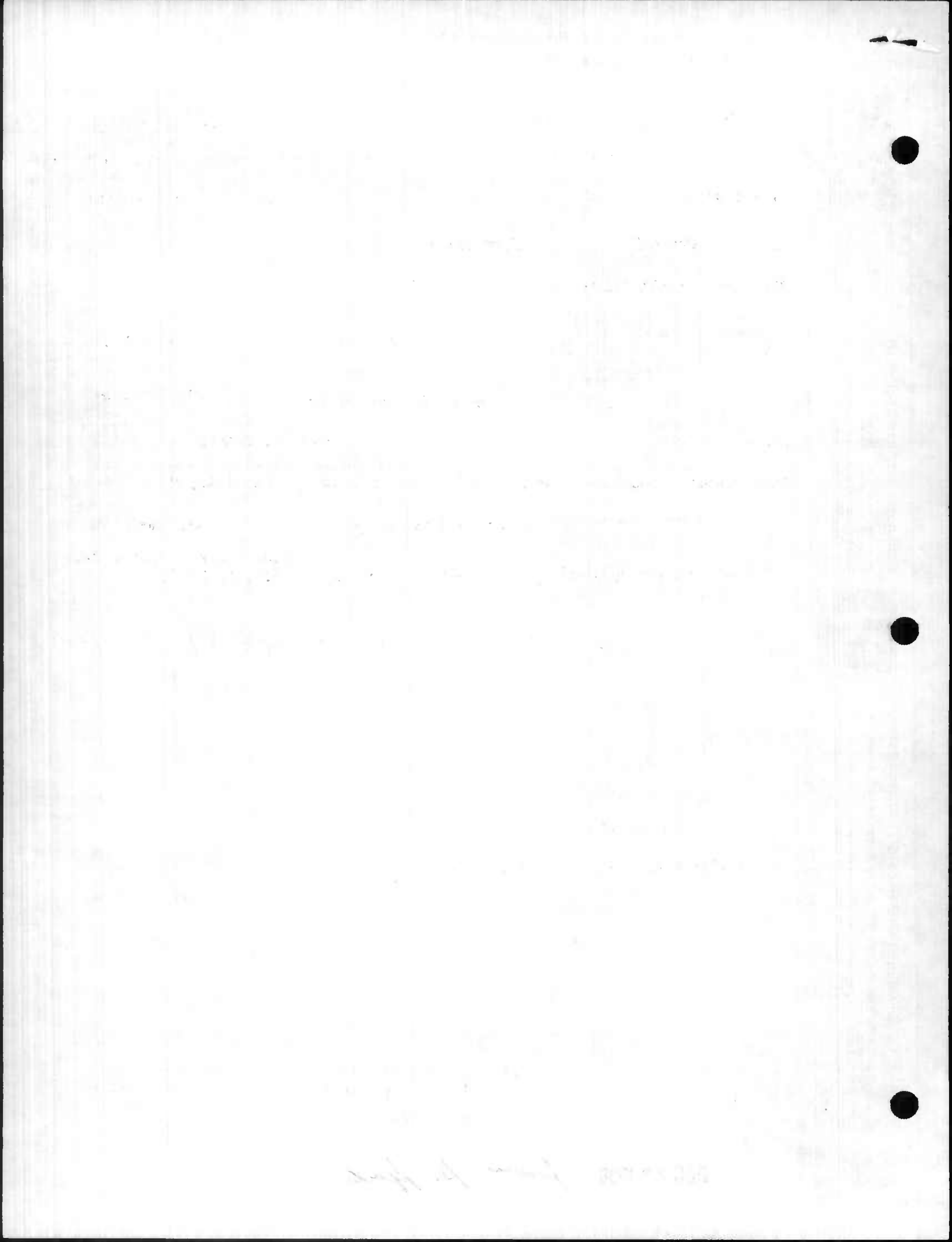
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



State of Maryland / Department of Health and Mental Hygiene 98 41127  
Certificate of Death Reg. No.

Reg. No.

DMMH 16 Rev 6/95





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **98 41128**  
**Certificate of Death**

Reg. No.

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) <b>Mary Elizabeth Hanks</b>				2. Date of Death Month <b>December</b> Day <b>17</b> , Year <b>1998</b>		3. Time of Death <b>1317</b>	
4a. Facility Name (If not institution, give street and number) <b>14728 Patton Way</b>				4b. City, Town, or Location of Death <b>Scotland</b>		4c. County of Death <b>St. Mary's</b>	
5. Social Security Number <b>312-16-9907</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>80</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) <b>February 13, 1918</b>	9. Birthplace (State or Foreign Country) <b>Indiana</b>
Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>St. Mary's</b>		10c. City, Town or Location <b>Scotland</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>14728 Patton Way</b>				10f. Zip Code <b>20687</b>		10g. Citizen of What Country? <b>United States</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (14 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Civil Service</b>		16b. Kind of Business/Industry <b>U.S. Defense</b>	
17. Father's Name (First, Middle, Last) <b>Charles Brookshire</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Goldie Worthington</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Donald Baugh, Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>164 South East Prim Vista Blvd., Port St. Lucie, FL 34983</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Arlington National Cemetery</b>		20c. Location - City or Town, State <b>Arlington, Virginia</b>		20d. Date <b>12-28-98</b>	
21. Signature of Funeral Home Licensee <b>Edward N. Brinsfield, Jr. M00052</b>				22. Name and Address of Facility <b>Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, MD 20650</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Cardiac arrest</b> Due to (or as a consequence of): b. <b>coronary artery disease</b> Due to (or as a consequence of): c. <b>hyperlipidemia</b> Due to (or as a consequence of): d.  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier <b>Chick</b>				29c. License number <b>D15369</b>		29d. Date signed (Month, Day, Year) <b>12/21/98</b>	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Umed K. Shah, M.D. Leonardtown, Maryland 20650</b>							
31. Date filed (Month, Day, Year) <b>DEC 21 1998</b>				32. Registrar's Signature <b>G. Sparks</b>			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

810B

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41129

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DOROTHY Barbara HARWOOD				2. Date of Death Month Day Year DECEMBER 27, 1998		3. Time of Death 2313 PM	
	4a. Facility Name (If not institution, give street and number) Calvert Memorial Hospital				4b. City, Town, or Location of Death Prince Frederick		4c. County of Death Calvert	
Funeral Director	5. Social Security Number 483-58-7760	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 56 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) September 29, 1942	9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland	10b. County Calvert	10c. City, Town or Location St. Leonard			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 1218 Calvert Beach Road			10f. Zip Code 20685		10g. Citizen of What Country? U.S.A.		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2yrs		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Register Nurse		16b. Kind of Business/Industry Hospital			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Joseph Raymond Tippet				18. Mother's Name (First, Middle, Maiden Surname) Betty Lucy Morgan			
	19a. Informant's Name/Relationship (Type, Print) James G. Harwood, Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1218 Calvert Beach Road, St. Leonard, MD 20685			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Charles Memorial Gardens		Date 12/31/98		20c. Location - City or Town, State Leonardtown, MD	
	21. Signature of Funeral Service Licensee Michael Gardiner				22. Name and Address of Facility Matingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, MD 20650			
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) HEPATIC FAILURE Due to (or as a consequence of): CIRRHOSIS OF LIVER. Due to (or as a consequence of): CRYPTOGENIC						Approximate Interval Between Onset and Death 2 WEEKS MORE THAN 2 YEARS MORE THAN 2 YEARS.	
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ACUTE RENAL FAILURE HYPERKALEMIA							
	23c. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown							
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
			28d. Describe how Injury occurred		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Gyan Chand Surana		29c. License number D50653		29d. Date signed (Month, Day, Year) 12-28-98	
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GYAN CHAND SURANA 7501 SURRATTS ROAD. CLINTON. M.D.							
	31. Date filed (Month, Day, Year) DEC 29 1998		32. Registrar's Signature B. Sparks					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **98 41130**  
Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

STEPHANIE LYNN HARTUNG

2. Date of Death

Month Day Year  
DECEMBER 29 1998

3. Time of Death

8:25 AM

4a. Facility Name (If not institution, give street and number)

MEMORIAL HOSPITAL

4b. City, Town, or Location of Death

CUMBERLAND

4c. County of Death

ALLEGANY

5. Social Security Number

214-11-2112 DI

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

30 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
NOV 21 1968

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ALLEGANY

10c. City, Town or Location

CUMBERLAND

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

515 WELCH AVENUE

10f. Zip Code

21502

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
0

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

NONE

16b. Kind of Business/Industry

NONE

17. Father's Name (First, Middle, Last)

PAUL FRED HARTUNG JR.

18. Mother's Name (First, Middle, Maiden Surname)

MOLLY BURK

19a. Informant's Name/Relationship (Type, Print)

MOLLY BURK HARTUNG

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

MOTHER 13 GLENVIEW DRIVE LAVALE MARYLAND 21502

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

CUMBERLAND CREMATORY DEC 29, 1998

Date

20c. Location - City or Town, State

CUMBERLAND MARYLAND

21. Signature of Funeral Service Licensee

Dale L. Merritt

22. Name and Address of Facility

MERRITT-ADAMS FUNERAL HOME

404 DECATUR STREET CUMBERLAND MARYLAND

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. CARDIAC ARRYTHEMIA

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

SUDDEN

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. PNEUMONIA

Due to (or as a consequence of):

1 MONTH

c. SEIZURE DISORDER

Due to (or as a consequence of):

30 YEARS

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

MENTAL RETARDATION

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28e. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Dale L. Merritt

29c. License number

D 09159

29d. Date signed (Month, Day, Year)

DECEMBER 29 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR PAUL SNOW

124 WEST 3rd STREET CUMBERLAND MARYLAND 21502

31. Date filed (Month, Day, Year)

DEC 30 1998

32. Registrar's Signature

Dale L. Merritt

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41131

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) ALICE IRENE HOPKINS				2. Date of Death Month Day Year DECEMBER 26 1998				3. Time of Death 8:55 PM			
4a. Facility Name (If not institution, give street and number) FROSTBURG VILLAGE NURSING HOME				4b. City, Town, or Location of Death FROSTBURG				4c. County of Death ALLEGANY			
5. Social Security Number 217-10-7582		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 89 Yrs.		8. Date of Birth (Month, Day, Year) MAY 24 1909		9. Birthplace (State or Foreign Country) MARYLAND			
Usual Residence of Decedent				10c. City, Town or Location CUMBERLAND				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
10e. State MARYLAND		10b. County ALLEGANY		10f. Zip Code 21502				10g. Citizen of What Country? U.S.A.			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: WHITE			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOUSE WIFE				16b. Kind of Business/Industry HOUSE WIFE			
17. Father's Name (First, Middle, Last) JOHN DENNISON				18. Mother's Name (First, Middle, Maiden Surname) CHATTIE MILLER							
19a. Informant's Name/Relationship (Type, Print) ROBERT THOM NEPHEW				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 453 COLUMBIA STREET CUMBERLAND MARYLAND 21502							
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) HILLCREST CEMETERY DEC 30 1998				20c. Location - City or Town, State CUMBERLAND MARYLAND			
21. Signature of Funeral Service Licensee <i>Dale L. Merritt</i>				22. Name and Address of Facility MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND							
23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) e. <i>Acute myocardial infarction</i> Due to (or as a consequence of): b. <i>Coronary artery disease</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death <i>One day</i> <i>About Ten years</i>											
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>HYPERTENSION, DIABETES MELLITUS</i> <i>HYPOTHYROIDISM, CONGESTIVE HEART FAILURE</i> <i>CHRONIC OBSTRUCTIVE LUNG DISEASE</i>								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <i>Harjit Sidhu</i>				29c. License number D 26907			
29d. Date signed (Month, Day, Year) DEC 28 1998											
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR HARJIT SIDHU 925 BISHOP WALSH ROAD CUMBERLAND MARYLAND 21502											
31. Date filed (Month, Day, Year) DEC 29 1998				32. Registrar's Signature <i>B. Sparks</i>							



Handwritten signature or initials

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 41132

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Bernard F. Hansrote, Sr.				2. Date of Death Month Day Year DECEMBER 17, 1998		3. Time of Death 6:30PM	
	4a. Facility Name (If not Institution, give street and number) Sacred Heart Hospital				4b. City, Town, or Location of Death Cumberland		4c. County of Death Allegany	
Funeral Director	5. Social Security Number 217-18-4640	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 75 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Jul 17, 1923	9. Birthplace (State or Foreign Country) MD	
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State MD	10b. County Allegany		10c. City, Town or Location Cumberland			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number 912 Shades Lane			10f. Zip Code 21502		10g. Citizen of What Country? USA		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+)			18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Retired Machinist			16b. Kind of Business/Industry B & O Railroad	
	17. Father's Name (First, Middle, Last) Edward Adam Hansrote				18. Mother's Name (First, Middle, Maiden Surname) Jean May (Kear)			
	19a. Informant's Name/Relationship (Type, Print) Martha E. Hansrote-wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 912 Shades Lane Cumberland MD 21502			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Greenmount Cemetery		Data 12/21		20c. Location - City or Town, State Cumberland MD	
	21. Signature of Funeral Service Licensee James F. Scarpelli				22. Name and Address of Facility Scarpelli Funeral Home, P.A. Cumberland MD 21502			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Respiratory failure Due to (or as a consequence of): b. severe pulm. emphysema Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 2 weeks							
	23a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Congestive heart failure Cardiac arrhythmias Cor pulmonale							
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)				28e. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and title of certifier R. Espina, MD				29c. License number D03459		29d. Date signed (Month, Day, Year) DECEMBER 18, 1998	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) R. ESPINA, MD 402 Seton Drive, Cumberland, MD							
	31. Date filed (Month, Day, Year) DEC 21 1998				32. Registrar's Signature B. Spaw			
	State Registrar							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41133

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

EVELYN M. HARTMAN

2. Date of Death

Month Day Year  
December 15 1998

3. Time of Death

5:45 p.m.

4a. Facility Name (If not institution, give street and number)

Sacred Heart Hospital

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

Funeral  
Director

5. Social Security Number

234-56-7470

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

62

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
March 29, 1936

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

WV

10b. County

Mineral

10c. City, Town or Location

Keyser

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

41 "C" Street

10f. Zip Code

26726

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married  
☐ Widowed ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
6

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Seamstress

16b. Kind of Business/Industry

Garment Manufacturing

17. Father's Name (First, Middle, Last)

David Pierce Cooper

18. Mother's Name (First, Middle, Maiden Surname)

Alta Marie Saucer

19a. Informant's Name/Relationship (Type, Print)

Terry L. Cheshire/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

41 "C" Street Keyser, WV 26726

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

The Cumberland Crematory

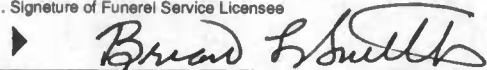
Date

Dec. 17  
1998

20c. Location - City or Town, State

Cumberland, MD

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Rotruck-Smith Funeral Home  
85 S. Main Street Keyser, WV 26726

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory Failure

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 Weeks

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Occlusion of Left Bronchus and Pleural Effusion

Due to (or as a consequence of):

Unknown

c. Chronic lymphocytic leukemia Stage IV

Due to (or as a consequence of):

5 Years

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D-17526

29d. Date signed (Month, Day, Year)

December 16, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John Mehanna, M.D. 902 Seton Drive Cumberland, MD 21502

31. Date filed (Month, Day, Year)

DEC 21 1998

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41134

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LILLIAN W. HICKMAN					2. Date of Death Month Day Year December 19, 1998		3. Time of Death 2:21 P.M.	
	4a. Facility Name (If not institution, give street and number) SOUTHERN MARYLAND HOSPITAL					4b. City, Town, or Location of Death CLINTON		4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 099-20-6879		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 77 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Nov. 19, 1921		9. Birthplace (State or Foreign Country) Washington, D.C.
	Usual Residence of Decedent								
10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Seat Pleasant			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10e. Street and Number 710 66th Avenue				10f. Zip Code 20743		10g. Citizen of What Country? United States			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Nurses Assistant			16b. Kind of Business/Industry Private		
17. Father's Name (First, Middle, Last) Levi Brown					18. Mother's Name (First, Middle, Maiden Surname) Lucy Colbert				
19a. Informant's Name/Relationship (Type, Print) Shirlene A. Beard - Daughter					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 710 66th Avenue, Seat Pleasant, MD 20743				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Harmony Memorial Park		20c. Date 12/28/98		20d. Location - City or Town, State Landover, MD		
21. Signature of Funeral Service Licensee John T. Stewart III					22. Name and Address of Facility STEWART FUNERAL HOME, Inc. 4001 Benning Road, N. E., Washington, D. C.				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
immediate Cause (Final disease or condition resulting in death) a. CARDIAC DISEASE Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.									
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown									
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred					28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier J. Stewart					29c. License number 20391		29d. Date signed (Month, Day, Year) DECEMBER 24, 1998		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. JEREMY KILMAN 6525 BALLREST ROAD, HYATTSVILLE MD 20782									
31. Date filed (Month, Day, Year) DEC 24 1998					32. Registrar's Signature [Signature]				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

REC 34 800



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41135

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

WILLIAM HARRIS

2. Date of Death

Month Day Year  
DECEMBER 15, 1998

3. Time of Death

02:08

4a. Facility Name (If not institution, give street and number)

3703 WALNUT LANE

4b. City, Town, or Location of Death

SUITLAND

4c. County of Death

PRINCE GEORGES

Funeral  
Director

5. Social Security Number

230-22-5324

6. Sex

1 ☐ M 2 ☐ F  
X

7. Age (In yrs. last birthday)

72

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

9. Birthplace (State or Foreign Country)

March 7, 1926 Crewe, Virginia

Usual Residence of Decedent

10a. State

10b. County

10c. City, Town or Location

10d. Inside City Limits

Maryland Prince George's

Suitland

1 ☒ Yes 2 ☐ No

10a. Street and Number

3703 Walnut Lane

10f. Zip Code

20746

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: 1945-6513. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1+

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Diesel Engineering Instructor Government

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

Eddie Harris

18. Mother's Name (First, Middle, Maiden Surname)

Lucy Ann Perry

19a. Informant's Name/Relationship (Type, Print)

Gloria Harris wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3703 Walnut Lane Suitland, MD 20746

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Arlington National Cem. 12-23

Date

20c. Location - City or Town, State

Arlington, Virginia

21. Signature of Funeral Service Licensee

J. P. Marshall

22. Name and Address of Facility

MARSHALL'S FUNERAL HOME

4308 Suitland Road Suitland, MD 20746

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CANCER OF PROSTATE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☒ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Mario F. Golie, Jr. MD

29c. License number

D33954

29d. Date signed (Month, Day, Year)

DECEMBER 16, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARIO F. GOLIE JR MD 3001 HOSPITAL DRIVE, CHEVERLY, MARYLAND

31. Date filed (Month, Day, Year)

DEC 21 1998

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

(12) IVa

1. The first part of the document is a letter from the President of the United States to the Congress, dated January 1, 1861. It is a very important document, as it contains the President's message to the Congress at the beginning of his first term.

2. The second part of the document is a report from the Secretary of the Treasury, dated January 1, 1861. It contains information about the state of the Treasury and the country's finances at the beginning of the year.

3. The third part of the document is a report from the Secretary of the Interior, dated January 1, 1861. It contains information about the state of the Interior and the country's resources at the beginning of the year.

4. The fourth part of the document is a report from the Secretary of the Navy, dated January 1, 1861. It contains information about the state of the Navy and the country's naval resources at the beginning of the year.

5. The fifth part of the document is a report from the Secretary of the War, dated January 1, 1861. It contains information about the state of the War and the country's military resources at the beginning of the year.

6. The sixth part of the document is a report from the Secretary of the State, dated January 1, 1861. It contains information about the state of the State and the country's diplomatic relations at the beginning of the year.

7. The seventh part of the document is a report from the Secretary of the Agriculture, dated January 1, 1861. It contains information about the state of the Agriculture and the country's agricultural resources at the beginning of the year.

8. The eighth part of the document is a report from the Secretary of the Commerce, dated January 1, 1861. It contains information about the state of the Commerce and the country's commercial resources at the beginning of the year.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41136

Physician (Medical Examiner)	1. Decedent's Name (First, Middle, Last) <u>Reginald Hawkins</u>				2. Date of Death Month <u>December</u> Day <u>15</u> Year <u>1998</u>		3. Time of Death <u>5:36 pm</u>	
	4a. Facility Name (If not institution, give street and number) <u>Montgomery General Hospital</u>				4b. City, Town, or Location of Death <u>Olney</u>		4c. County of Death <u>Montgomery</u>	
Funeral Director	5. Social Security Number <u>578-70-9755</u>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <u>45</u> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <u>June 23, 1953</u>	9. Birthplace (State or Foreign Country) <u>Washington, D.C.</u>
	Usual Residence of Decedent							
10a. State <u>Maryland</u>		10b. County <u>Prince George's</u>		10c. City, Town or Location <u>Upper Marlboro</u>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <u>123 Harry S. Truman Drive, apt.#12</u>				10f. Zip Code <u>20774</u>		10g. Citizen of What Country? <u>U.S.A.</u>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <u>BLACK</u>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>11th</u> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Supervisor</u>			16b. Kind of Business/Industry <u>Private</u>	
17. Father's Name (First, Middle, Last) <u>Warren Hawkins</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>Aisha Garris</u>				
19a. Informant's Name/Relationship (Type, Print) <u>Denise Hawkins/Wife</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>123 Harry S. Truman Drive, #12, Upper Marlboro, Maryland 20774</u>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Chesapeake Crematory</u>		Date <u>12/21</u>		20c. Location - City or Town, State <u>Beltsville, Maryland</u>		
21. Signature of Funeral Service Licensee <u>Nancy A. Perentis</u>				22. Name and Address of Facility <u>J.B. Jenkins Funeral Home</u> <u>7474 Landover Road, Landover, Maryland 20785</u>				
23a. Part I. Enter the <u>immediate</u> or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <u>HIV Encephalitis</u> Due to (or as a consequence of): <u>End Stage Acquired Immunodeficiency Syndrome</u>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <u>Due to (or as a consequence of):</u>								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Dilated Cardiomyopathy</u> <u>Malignant Hypertension</u>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <u>M</u>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier. <u>Robert Weinstein</u>				29c. License number <u>042777</u>		29d. Date signed (Month, Day, Year) <u>December 15, 1998</u>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Richard Weinstein 18111 Prince Philip Drive #210 Olney, MD 20832</u>								
31. Date filed (Month, Day, Year) <u>DEC 21 1998</u>		32. Registrar's Signature <u>[Signature]</u>						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit card.

DEC 1 1968

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41137

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Rosa Marie Hamilton					2. Date of Death Month: December Day: 21 Year: 1998		3. Time of Death 9:38AM	
	4a. Facility Name (If not institution, give street and number) Ft. Washington Hospital					4b. City, Town, or Location of Death Ft. Washington		4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 213-26-7263		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 67	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) May 6, 1931		9. Birthplace (State or Foreign Country) Index, VA.
	Usual Residence of Decedent								
10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Accokeek				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 2801 Marshall Hall Rd.					10f. Zip Code 20607		10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5th College (1-4or 5+)					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Disabled		16b. Kind of Business/Industry N/A		
17. Father's Name (First, Middle, Last) Wesley Thomas Scott					18. Mother's Name (First, Middle, Maiden Surname) Fannie Mae Pates				
19a. Informant's Name/Relationship (Type, Print) Albert H. Hamilton/Son					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as item 10				
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory			Date 12/21/98		20c. Location - City or Town, State Alexandria, Va.	
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility George P. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill, Md. 20745				
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pneumonia Due to (or as a consequence of): Respiratory Failure Due to (or as a consequence of): Chronic Obstructive Lung Disease Due to (or as a consequence of): Non small cell of lung									Approximate Interval Between Onset and Death Unknown Unknown Unknown Unknown
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29b. Signature and Title of Certifier 			29c. License number D50454		29d. Date signed (Month, Day, Year) December 21, 1998	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Arastoo Yazdani, M.D. 1328 Southern Ave. S.E. #202 Washington, D.C. 20032									
31. Date filed (Month, Day, Year) DEC 21 1998			32. Registrar's Signature 						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DEC 1 1961



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 41138

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Walter H. Horn

2. Date of Death

Month Day Year  
DECEMBER 21 1998

3. Time of Death

7:36 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Doctor's Community Hospital

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince George's

5. Social Security Number

578-09-9410

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
May 12, 1916

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Hyattsville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4113 56th Avenue

10f. Zip Code

20781

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates: WW II13. Was Decedent of Hispanic Origin? (Specify Yes or No.  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Printer

16b. Kind of Business/Industry

Newspaper Industry

17. Father's Name (First, Middle, Last)

Walter H. Horn, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Mary Anna Clark

19a. Informant's Name/Relationship (Type, Print)

Anna Horn - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4113 56th Avenue, Hyattsville, Maryland 20781

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Fort Lincoln Cemetery

Date

12/23/98

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee

Henry S. Ford

22. Name and Address of Facility

Gasch's Funeral Home, P.A.

4739 Baltimore Avenue, Hyattsville, MD 20781

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a.

Aspiration

Due to (or as a consequence of):

b.

Colonic pseudo-obstruction

Due to (or as a consequence of):

c.

Dehydration

Due to (or as a consequence of):

d.

Congestive heart failure

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) LastApproximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Colon Cancer

Compression fracture spine

Duodenal Ulcer

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending  
Investigation  
6 ☐ Could not be  
determined28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

W. Greene, M.D.

29c. License number

D38031

29d. Date signed (Month, Day, Year)

12/21/98

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Madalene Greene, M.D. 3231 Superior Lane A-4 Bowie MD 20715

State  
Registrar

31. Date filed (Month, Day, Year)

DEC 23 1998

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural," or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



DEC 5 1960

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41139

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) <b>JAMES LESTER HUNTER</b>				2. Date of Death Month <b>December</b> Day <b>20</b> Year <b>1998</b>		3. Time of Death <b>12:42 PM</b>	
4a. Facility Name (If not institution, give street and number) <b>Prince George's Hospital Center</b>				4b. City, Town, or Location of Death <b>Cheverly</b>		4c. County of Death <b>Prince George's</b>	
5. Social Security Number <b>578-52-5521</b>		6. Sex <b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>59</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>April 9, 1939</b>	
9. Birthplace (State or Foreign Country) <b>Washington, D.C.</b>							

Usual Residence of Decedent			10a. State <b>Maryland</b>		10b. County <b>Prince George's</b>		10c. City, Town or Location <b>Landover</b>		10d. Inside City Limits <b>1</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
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10e. Street and Number <b>3105 - 82nd Avenue</b>				10f. Zip Code <b>20785</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
---	--	--	--	-------------------------------	--	--	--

11. Marital Status <b>1</b> <input type="checkbox"/> Never Married <b>2</b> <input checked="" type="checkbox"/> Married <b>3</b> <input type="checkbox"/> Widowed <b>4</b> <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
--	--	---	--	--	--	---	--

15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>12th</b>		College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Painter</b>		16b. Kind of Business/Industry <b>Private</b>	
--	--	--------------------	--	---	--	--	--

17. Father's Name (First, Middle, Last) <b>Lester B. Hunter</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Eleanor Terrell</b>			
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19a. Informant's Name/Relationship (Type, Print) <b>Mary E. Hunter/Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3105-82nd Avenue, Landover, Maryland 20785</b>			
--	--	--	--	--	--	--	--

20a. Method of Disposition <b>1</b> <input checked="" type="checkbox"/> Burial <b>2</b> <input type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State <b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Harmony Memorial Park</b>		Date <b>12/26 1998</b>		20c. Location - City or Town, State <b>Landover, Maryland</b>	
--	--	--	--	---------------------------	--	--	--

21. Signature of Funeral Service Licensee <b>Nancy A. Perenti</b>		22. Name and Address of Facility <b>J. B. JENKINS FUNERAL HOME</b> <b>7474 Landover Road, Landover, Maryland 20785</b>					
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23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Acute Myocardial Infarction 12/10/98</b> Due to (or as a consequence of): <b>Hypertensive Cardiovascular disease years.</b> Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):		Approximate Interval Between Onset and Death	
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Gangrene of Right Leg.</b> <b>Diabetes Mellitus</b>				23b. Did tobacco use contribute to the cause of death? <b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No <b>3</b> <input type="checkbox"/> Probably <b>4</b> <input type="checkbox"/> Unknown			
				24a. Was an autopsy performed? <b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <b>1</b> <input type="checkbox"/> Yes <b>2</b> <input type="checkbox"/> No	

25. Was case referred to medical examiner? <b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <b>1</b> <input checked="" type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA Other: <b>4</b> <input type="checkbox"/> Nursing Home <b>5</b> <input type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify)					
27. Manner of Death <b>1</b> <input checked="" type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending investigation <b>2</b> <input type="checkbox"/> Accident <b>6</b> <input type="checkbox"/> Could not be determined <b>3</b> <input type="checkbox"/> Suicide <b>4</b> <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <b>1</b> <input type="checkbox"/> Yes <b>2</b> <input type="checkbox"/> No	
28d. Describe how Injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)			

29a. Certifier (Check only one) <b>1</b> <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
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29b. Signature and title of certifier <b>Rakesh Arora, MD</b>		29c. License number <b>D20108</b>		29d. Date signed (Month, Day, Year) <b>12/21/98</b>	
--	--	--------------------------------------	--	--	--

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Rakesh Arora, MD, 14300 Gallant Fox, Suite #222, Bowie, Maryland 20715</b>							
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31. Date filed (Month, Day, Year) <b>DEC 23 1998</b>				32. Registrar's Signature			
---	--	--	--	---------------------------	--	--	--

To Be Completed by Funeral Director

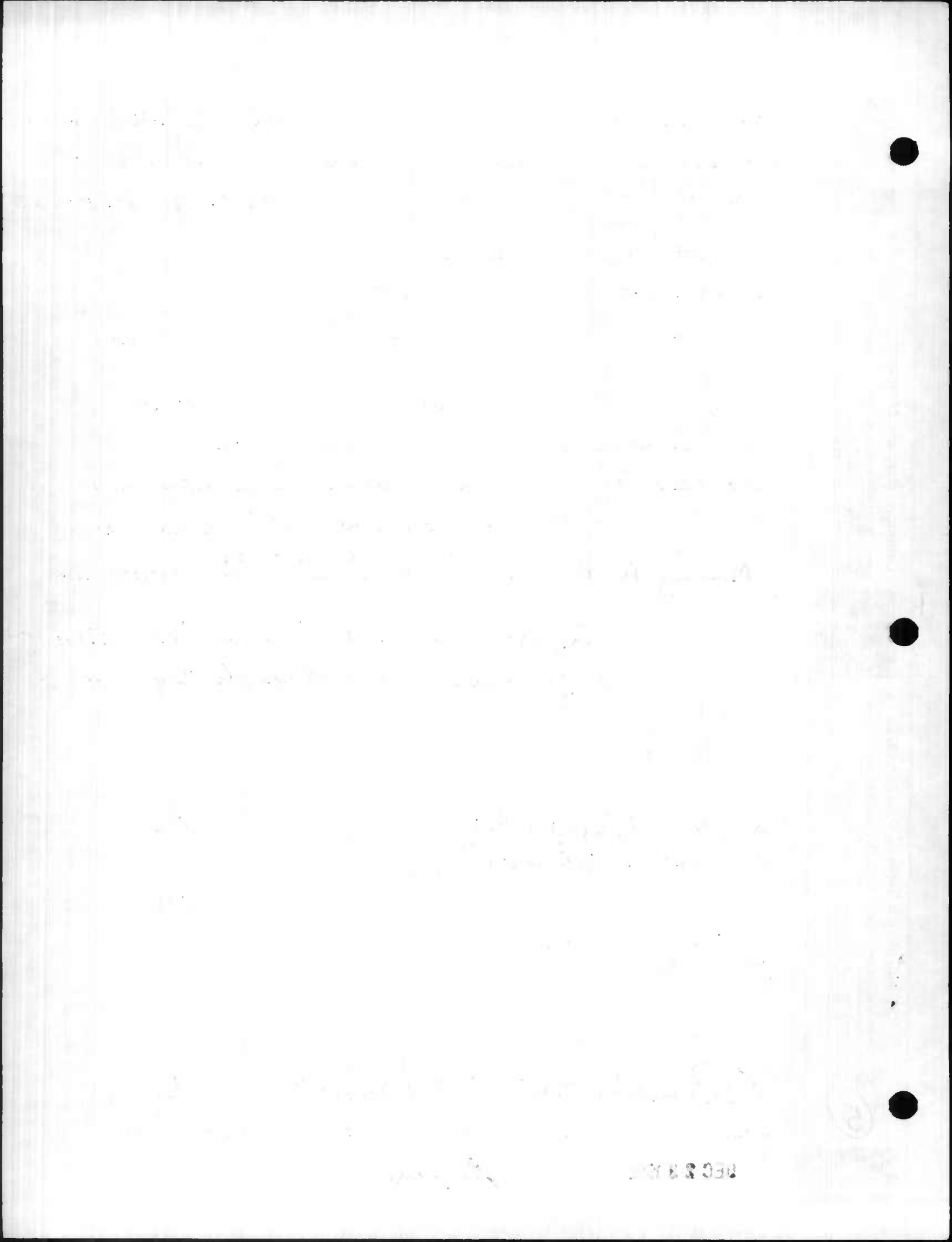
Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **98 41140**  
**Certificate of Death**

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>HELEN LOUISE HALEY</b>				2. Date of Death Month <b>December</b> Day <b>20</b> Year <b>1998</b>		3. Time of Death <b>5:45AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Washington Adventist Hospital</b>				4b. City, Town, or Location of Death <b>Takoma Park</b>		4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>577-24-5392</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>86</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>August 1, 1912</b>	9. Birthplace (State or Foreign Country) <b>Virginia</b>
	Usual Residence of Decedent							
10a. State <b>MD</b>		10b. County <b>Prince Georges</b>		10c. City, Town or Location <b>Hyattsville</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>1001 Chillum Road</b>				10f. Zip Code <b>20782</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11th</b> Collega (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Medical Technician</b>			16b. Kind of Business/Industry <b>Howard University</b>	
17. Father's Name (First, Middle, Last) <b>James Hogan</b>				18. Mother's Name (First, Middle, Maiden Sumama) <b>Audrey Stewart</b>				
19a. Informant's Name/Relationship (Type, Print) <b>James L. Haley, Sr.</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1001 Chillum Rd. Hyattsville, MD 20782</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mt. Olivet Cemetery</b>		20c. Location - City or Town, State <b>12-26-98 Washington, DC</b>		
21. Signature of Funeral Service Licensee <b>J. P. Marshall</b>				22. Name and Address of Facility <b>Marshall's Funeral Home, Inc. 4217 9th Street N.W. Washington, DC 20011</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <b>respiratory failure</b> Due to (or as a consequence of): b. <b>aspiration pneumonia</b> Due to (or as a consequence of): c. <b>stroke</b> Due to (or as a consequence of): d. <b>Atherosclerosis</b>								Approximate Interval Between Onset and Death <b>1 day</b> <b>1 day</b> <b>1 day</b> <b>years</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <b>Rashid Kaghari</b>				29c. License number <b>D33372</b>		29d. Date signed (Month, Day, Year) <b>December 20, 1998</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>344 University Blvd West Silver Spring MD 20904</b>								
31. Date filed (Month, Day, Year) <b>DEC 23 1998</b>				32. Registrar's Signature <b>[Signature]</b>				

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

Reg. No.

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>Roscoe Vernon Johnson</b>					2. Date of Death Month <b>Dec.</b> Day <b>26</b> Year <b>1998</b>		3. Time of Death <b>22:52</b>			
	4a. Facility Name (If not institution, give street and number) <b>Washington County Hospital</b>				4b. City, Town, or Location of Death <b>Hagerstown</b>		4c. County of Death <b>Washington</b>				
<b>Funeral Director</b>	5. Social Security Number <b>234-46-8337</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (in yrs. last birthday) <b>65</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>April 24, 1933</b>		9. Birthplace (State or Foreign Country) <b>West Virginia</b>		
	Usual Residence of Decedent										
10a. State <b>West Virginia</b>			10b. County <b>Berkeley</b>		10c. City, Town or Location <b>Falling Waters</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>166 Broadview Court</b>					10f. Zip Code <b>25419</b>		10g. Citizen of What Country? <b>United States</b>				
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>9</b>					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Salesman</b>			16b. Kind of Business/Industry <b>Automobile Dealer</b>			
17. Father's Name (First, Middle, Last) <b>Boyd Johnson</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Lola (Unknown)</b>						
19a. Informant's Name/Relationship (Type, Print) <b>Karen A. Johnson</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>25419</b> <b>166 Broadview Court, Falling Waters, West Virginia</b>						
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Hagerstown Crematory</b>			20c. Location - City or Town, State <b>12-28-98 Hagerstown, Maryland</b>					
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility <b>Minnich Funeral Home</b> <b>415 E. Wilson Blvd., Hagerstown, Maryland 21740</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Acute Myocardial Infarction 12 hours</b> Due to (or as a consequence of):  <b>b.</b> Due to (or as a consequence of):  <b>c.</b> Due to (or as a consequence of):  <b>d.</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Renal failure</b> <b>history of ruptured aortic aneurysm</b>										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					28. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					29b. Signature and title of certifier 		29c. License number <b>D 46231</b>		29d. Date signed (Month, Day, Year) <b>December 27, 1998</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. Paine 370 Mill St. Hagerstown, MD</b>											
31. Date filed (Month, Day, Year) <b>DEC 28 1998</b>					32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

Johnson, Roscoe





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41142

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Virginia Johnson</b>				2. Date of Death Month <b>December</b> Day <b>24</b> Year <b>1998</b>		3. Time of Death <b>1248</b>	
4a. Facility Name (If not institution, give street and number) <b>PENINSULA REGIONAL MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>SALISBURY</b>		4c. County of Death <b>WICOMICO</b>	
5. Social Security Number <b>213-14-6148</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>83</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Aug. 29 1915</b>	
9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>Wicomico</b>		10c. City, Town or Location <b>Quantico</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>4522 Whitehaven Road</b>		10f. Zip Code <b>21856</b>		10g. Citizen of What Country? <b>U.S.A</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Domestic</b>		16b. Kind of Business/Industry <b>None</b>		17. Father's Name (First, Middle, Last) <b>James Ernest Shiles</b>	
18. Mother's Name (First, Middle, Maiden Surname) <b>Josephine Price</b>		19a. Informant's Name/Relationship (Type, Print) <b>Madelyn Shiles (Niece)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7591 Buckman Ave. Salisbury, Md. 21801</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	
20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Green Acres</b>		20c. Date <b>12/30/98</b>		20d. Location - City or Town, State <b>Salisbury, Md.</b>		21. Signature of Funeral Service Licensee <b>Gladys B. Stewart</b>	
22. Name and Address of Facility <b>Stewart Funeral Home 821 West Rd. Salisbury, Md. 21801</b>		23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Acute myocardial infarction</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		23c. Approximate Interval Between Onset and Death <b>4 DAYS</b>	
23d. Immediate Cause (Final disease or condition resulting in death) <b>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</b>		23e. Due to (or as a consequence of): <b>Due to (or as a consequence of):</b>		23f. Due to (or as a consequence of): <b>Due to (or as a consequence of):</b>		23g. Due to (or as a consequence of): <b>Due to (or as a consequence of):</b>	
23h. Pert 2. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert 1. <b>Hypertension</b> <b>Revised Baseline</b>		23i. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		23j. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		23k. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
23l. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		23m. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		23n. Date of Injury (Month, Day, Year) <b>11/04</b>		23o. Time of Injury <b>M</b>	
23p. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		23q. Describe how injury occurred		23r. Location (Street and Number or Rural Route Number, City or Town, State)		23s. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	
23t. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		23u. Signature and title of certifier <b>[Signature]</b>		23v. License number <b>D39813</b>		23w. Date signed (Month, Day, Year) <b>12/24/98</b>	
23x. Name and address of person who completed cause of death (item 23e) (Type, Print) <b>MARKINS MD 1104 deathway Drive, Salisbury MD 21804</b>		23y. Date filed (Month, Day, Year) <b>DEC 28 1998</b>		23z. Registrar's Signature <b>[Signature]</b>		23aa. State Registrar <b>11</b>	



Amended Item #20b per F. Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

12/28/98 Carroll County H.D. State of Maryland / Department of Health and Mental Hygiene

jab

## Certificate of Death

Reg. No.

98 41143

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Ernest O. Jenkins

2. Date of Death  
Month Day Year

Dec. 25 1998

3. Time of Death

11:05 PM

4a. Facility Name (If not institution, give street and number)

Westminster Nursing Home

4b. City, Town, or Location of Death

Westminster

4c. County of Death

Carroll

Funeral  
Director

5. Social Security Number

220-07-1684

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

Oct. 3, 1911

9. Birthplace (State or Foreign  
Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Carroll

10c. City, Town or Location

Westminster

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10a. Street and Number

143 Bond Street

10f. Zip Code

21157

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?1 ☒ Yes 2 ☐ NoIf Yes, Give  
Year or Dates: WW II13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
if Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

Unknown

College (14 or 5+)

College (14 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Carpenter Homes

16b. Kind of Business/Industry

Self-employed

17. Father's Name (First, Middle, Last)

Ernest H. Jenkins

18. Mother's Name (First, Middle, Maiden Surname)

Annie E. Hess

19a. Informant's Name/Relationship (Type, Print)

Mr. Allan W. Jenkins Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

143 Bond Street Apt. A Westminster, MD 21157

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Wesley Freedom Cemetery Dec. 30

20c. Location - City or Town, State

Sykesville, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Burrier-Queen Funeral Directors, P.A.

1212 W. Old Liberty Road Winfield, MD 21784

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e. Pneumonia

Due to (or as a consequence of):

b. COPD

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

1 wk

15y

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending  
investigation6 ☐ Could not be  
determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
injury28c. Injury et  
Work?1 ☐ Yes 2 ☐ No28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

John Middleton, M.D.

29c. License number

D 25443

29d. Date signed (Month, Day, Year)

12/28/98

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

John Middleton, M.D.

31. Date filed (Month, Day, Year)

DEC 28 1998

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41144

5 1/4

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>WILLIAM HAROLD JOHNSON</b>		2. Date of Death Month <b>December</b> Day <b>19</b> Year <b>1998</b>		3. Time of Death <b>12:56 AM</b>	
4a. Facility Name (If not institution, give street and number) <b>SOUTHERN MARYLAND HOSPITAL</b>			4b. City, Town, or Location of Death <b>CLINTON</b>		4c. County of Death <b>PRINCE GEORGES</b>
5. Social Security Number <b>225-68-3220</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>48</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>April 29, 1950</b>
9. Birthplace (State or Foreign Country) <b>Virginia</b>					
10a. State <b>Maryland</b>		10b. County <b>Prince Georges</b>		10c. City, Town or Location <b>Temple Hills</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number <b>4106 24th Avenue</b>		10f. Zip Code <b>20748</b>		10g. Citizen of What Country? <b>United States</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. <b>BLACK</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (14 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Metro Bus Operator</b>		16b. Kind of Business/Industry <b>Public Transportation</b>	
17. Father's Name (First, Middle, Last) <b>George Johnson</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Lorraine Jones</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Vollmer Y. Johnson /Wife</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4106 24th Avenue, Temple Hills, Md. 20748</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Charles Memorial Gardens</b>		20c. Location - City or Town, State <b>12/23/98 Leonardtown, Maryland</b>	
21. Signature of Funeral Service Licensee  <b>M859</b>		22. Name and Address of Facility <b>ALEXANDER S. POPE FUNERAL HOMES</b> <b>5538 Marlboro Pike, Forestville, Md. 20747</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. ACUTE RESPIRATORY FAILURE</b> Due to (or as a consequence of): <b>b. PULMONARY SARCOIDOSIS</b> Due to (or as a consequence of): <b>c. CHRONIC RESPIRATORY FAILURE</b> Due to (or as a consequence of): <b>d. CONGESTIVE HEART FAILURE</b>					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier  <b>HASSAN HODJATI</b>		29c. License number <b>D0023383</b>		29d. Date signed (Month, Day, Year) <b>12-20-98</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>HASSAN HODJATI 7127 ALLE TOWN RD CAMP SPRING MD 20744</b>					
31. Date filed (Month, Day, Year) <b>DEC 23 1998</b>		32. Registrar's Signature 			

2091 2 2 330



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

MORRIS ERIC JACKSON

## Certificate of Death

Reg. No.

98 41145

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MORRIS E. JACKSON

2. Date of Death  
Month Day Year  
December 19, 19983. Time of Death  
6:16 A.M.

4a. Facility Name (If not institution, give street and number)

5004 Lee Jay Drive

4b. City, Town, or Location of Death

Capitol Heights

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

578-94-0270

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

36

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

9/29/62

9. Birthplace (State or Foreign Country)

Wash., D.C.

Usual Residence of Decedent

10a. State

Md.

10b. County

P.G.

10c. City, Town or Location

Greenbelt

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

7816 Hanover Pkwy. # 204

10f. Zip Code

20770

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Painter

16b. Kind of Business/Industry

Private Industry

17. Father's Name (First, Middle, Last)

Morris S. Jackson

18. Mother's Name (First, Middle, Maiden Surname)

Margaret D. Nichols

19a. Informant's Name/Relationship (Type, Print)

Margaret D. Jackson/Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Same as # 10 above

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Forest Hills Mem. Cem.

Date

12/26/98

20c. Location - City or Town, State

Clinton, Md.

21. Signature of Funeral Service Licensee

Darryl W. Pratt

22. Name and Address of Facility

H.S. Washington & Sons Co., Inc.  
4925 Burroughs Ave., N.E., Wash., D.C. 2001923a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Gunshot Wound of Head

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☒ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) at scene

27. Manner of Death

1 ☐ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☒ Homicide

28a. Date of Injury

(Month, Day Year)

12/19/98

28b. Time of  
Injury

6:13 A M

28c. Injury at  
Work?1 ☐ Yes 2 ☒ No

28d. Describe how Injury occurred

subject shot

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

street

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)5004 Lee Jay Drive  
Capitol Heights, MD29a. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Dennis J. Chute

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

December 19, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dennis J. Chute

111 Penn Street, Baltimore, Maryland 21201

State  
Registrar

31. Date filed (Month, Day, Year)

DEC 24 1998

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



REC 5 1636

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 41146

William Raymond Keating Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

William R. Keating

2. Date of Death

Month Day Year  
December 25, 1998 2:07 am

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Lions Manor Nursing Home

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

5. Social Security Number

215-20-5309

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

70

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year  
Sep 10, 1928

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Allegany

10c. City, Town or Location

Cumberland

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

15604 Harvest Drive

10f. Zip Code

21502

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No  
If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Retired Safety Dept.

16b. Kind of Business/Industry

Textile

17. Father's Name (First, Middle, Last)

William Keating

18. Mother's Name (First, Middle, Maiden Surname)

Lena (Hadley)

19a. Informant's Name/Relationship (Type, Print)

Delores Keating-wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

15604 Harvest Drive Cumberland MD 21502

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Zion Lutheran Cemetery

Date

12/28

20c. Location - City or Town, State

Accident MD

21. Signature of Funeral Service Licensee

Nicholas J. Scarpelli

22. Name and Address of Facility

Scarpelli Funeral Home, P.A.  
Cumberland MD 21502

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Cerebrovascular Accident

Due to (or as a consequence of):

b.

Severe peripheral vascular disease

Due to (or as a consequence of):

c.

Diabetic Mellitus

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

1 hour

1 year

10 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetic nephropathy, Diabetic enteropathy  
Coronary heart disease, Severe depression

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☒ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural  
☐ Accident  
☐ Suicide  
☐ Homicide☐ Pending investigation  
☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

V. A. Ranjithan

29c. License number

D 19750

29d. Date signed (Month, Day, Year)

Dec 28, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

V.A. Ranjithan M.D., Lions Manor Nursing Home, Seton Drive Extended, Cumberland MD 21502

31. Date filed (Month, Day, Year)

DEC 29 1998

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Ethel Audrey King

Certificate of Death

Reg. No.

98 41147

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ETHEL KING

2. Date of Death

Month Day Year  
Dec 13 1998

3. Time of Death

0600

4a. Facility Name (If not institution, give street and number)

Anne Arundel Gen. Hosp.

4b. City, Town, or Location of Death

ANNAPOLIS

4c. County of Death

AA

Funeral  
Director

5. Social Security Number

218 74 3363

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
June 15, 1919

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Crownsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1520 Crownsville Road

10f. Zip Code

21032-2399

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) College (1-4 or 5+)

none

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

none

16b. Kind of Business/Industry

none

17. Father's Name (First, Middle, Last)

George William King

18. Mother's Name (First, Middle, Maiden Surname)

Mary Matilda Armiger

19a. Informant's Name/Relationship (Type, Print)

Mary A. Myers/niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4580 FSK Highway, Taneytown, MD 21787

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Harmony UMC Cem.

Date

12-17-98

20c. Location - City or Town, State

Owings, MD

21. Signature of Funeral Service Licensee

*[Signature]*

22. Name and Address of Facility

Rausch Funeral Home, Owings, MD 20736

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Arteriosclerotic Heart Disease

UNK.

Due to (or as a consequence of):

b. Hypertension

UNK.

Due to (or as a consequence of):

c. Diabetes

UNK.

Due to (or as a consequence of):

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Schizoaffective Disorder, Tardive dyskinesia, Glaucoma, Gastritis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

*[Signature]* Deputy

29c. License number

D 06054

29d. Date signed (Month, Day, Year)

12/13/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William P. Jones, MD 695 America

21035

31. Date filed (Month, Day, Year)

DEC 17 1998

32. Registrar's Signature

*[Signature]*

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 41148  
Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Dorothy May Logan

2. Date of Death

Month Day Year  
Dec. 27, 1998

3. Time of Death

8:15 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Homewood Nursing Center

4b. City, Town, or Location of Death

Williamsport

4c. County of Death

Washington

5. Social Security Number

215-50-5783

8. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Apr. 18, 1915

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1913 Maplewood Circle

10f. Zip Code

21740

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12College (1-4 or 5+)  
016a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Residence

17. Father's Name (First, Middle, Last)

Frank Royal Abbott

18. Mother's Name (First, Middle, Maiden Surname)

Hannah Elizabeth Winnemore

19a. Informant's Name/Relationship (Type, Print)

Norman Leroy Logan, Sr./Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1913 Maplewood Circle, Hagerstown, Maryland 21740

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Rest Haven Cemetery-Dec. 30, 1998 Hagerstown, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Douglas A. Fiery Funeral Home  
1331 Eastern Blvd., Hagerstown, Maryland 2174223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. PROTEIN CALORIE MALNUTRITION

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

2 MONTHS

Sequitely list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. NOT EATING

Due to (or as a consequence of):

2-3 MONTHS

c. SEVERE DEPRESSION OVERLAPSON'S

Due to (or as a consequence of):

1 YEAR

d. DEATH

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 8 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and Title of Certifier

29c. License number

D17067

29d. Date signed (Month, Day, Year)

12/28/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GREGORY C. METZNER, MD 747 KANTON AVENUE HAGERSTOWN, MD

31. Date filed (Month, Day, Year)

DEC 28 1998

32. Registrar's Signature

State  
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Dorothy A. Logan 12-27-98 8:15AM





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 41149

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Eloise Joan Larason

2. Date of Death

Month  
12Day  
22Year  
98

3. Time of Death

4:00 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

9544 Ocean Hwy

4b. City, Town, or Location of Death

Delmar

4c. County of Death

Wicomico

5. Social Security Number

194-12-3751

6. Sex

1 ☐ M2 ☒ F

7. Age (In yrs. last birthday)

80

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
9-25-1918

9. Birthplace (State or Foreign Country)

Panama

Usual Residence of Decedent

10a. State

De.

10b. County

Sussex

10c. City, Town or Location

Delmar

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

Rt. 1 Box 489 P

10f. Zip Code

19940

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

10

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Phys Ed Teacher

16b. Kind of Business/Industry

School

17. Father's Name (First, Middle, Last)

Walter S. Larason

18. Mother's Name (First, Middle, Maiden Surname)

Jennie D'Amour Larason

19a. Informant's Name/Relationship (Type, Print)

Allen B. Larason, Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Rt. 1 Box 489P Delmar, De. 19940

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cambridge Crematory

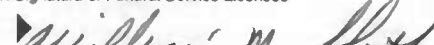
Date

12-23-98

20c. Location - City or Town, State

Cambridge, Md.

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Short Funeral Home, Inc.

13 E. Grove St. Delmar, De. 19940

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e.

Due to (or as a consequence of):

ASCUD

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

2

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

 P.O. DME

29c. License number

H50497

29d. Date signed (Month, Day, Year)

12/23/98

30. Name and address of person who completed cause of death (item 23e) (Type, Print)

188 Pine Street Rd

Salisbury

MD 21801

Christopher Snyder

31. Date filed (Month, Day, Year)

DEC 23 1998

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41150

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Robert Lee Livesay

2. Date of Death

Dec. 22, 1998

3. Time of Death

10:50 A.M.

4a. Facility Name (If not Institution, give street and number)

1645 Sams Creek Road

4b. City, Town, or Location of Death

Westminster

4c. County of Death

Carroll

Funeral  
Director

5. Social Security Number

414 32 6229

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

71

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 12, 1927

9. Birthplace (State or Foreign Country)

Tenn.

Usual Residence of Decedent

10a. State

Md.

10b. County

Carroll

10c. City, Town or Location

Westminster

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1645 Sams Creek Road

10f. Zip Code

21157

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
6

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Driver

16b. Kind of Business/Industry

Md. State Roads

17. Father's Name (First, Middle, Last)

Dewey Livesay

18. Mother's Name (First, Middle, Maiden Surname)

Addie Collinsworth

19a. Informant's Name/Relationship (Type, Print)

Opaline Livesay (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1645 Sams Creek Road Westminster, Md. 21157

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lake View Mem. Park

Date

12/24/98

20c. Location - City or Town, State

Sykesville, Md.

21. Signature of Funeral Service Licensee

Hany W. Haight

22. Name and Address of Facility

Sykesville, Md. 21784  
Haight Funeral Home & Chapel P.O.Box 195

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *metastatic carcinoma of lung*

Due to (or as a consequence of):

b. *to spine*

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

6 mos.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*chronic obstructive pulmonary disease*

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Hany W. Haight MD

29c. License number

D38915

29d. Date signed (Month, Day, Year)

12/23/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FRE 101 295 Stoner Ave Westminster MD 21157

31. Date filed (Month, Day, Year)

DEC 23 1998

32. Registrar's Signature

Beverly B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41151

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Anna Amelia Long				2. Date of Death Month Day Year December 18, 1998				3. Time of Death 3:54 AM		
	4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital				4b. City, Town, or Location of Death Frederick				4c. County of Death Frederick		
Funeral Director	5. Social Security Number 216-22-7967		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 72 Yrs.		8. Date of Birth (Month, Day, Year) Mar. 15, 1926		9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent										
10a. State Maryland		10b. County Frederick		10c. City, Town or Location Rocky Ridge				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
10e. Street and Number 10502-A Rocky Ridge Rd.				10f. Zip Code 21778		10g. Citizen of What Country? U.S.A.					
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) homemaker			16b. Kind of Business/Industry own home				
17. Father's Name (First, Middle, Last) Ezra Arbaugh					18. Mother's Name (First, Middle, Maiden Surname) Bessie Flohr						
19a. Informant's Name/Relationship (Type, Print) Cheryl R. Long/ daughter					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10502-A Rocky Ridge Rd., Rocky Ridge, MD 21778						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Mountain View Cemetery		Date 12/21/98		20c. Location - City or Town, State Union Bridge, MD				
21. Signature of Funeral Service Licensee Catharine D. Wenzler			22. Name and Address of Facility Hartzler Funeral Home 6 E. Broadway Union Bridge, MD 21791								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Bilateral Pneumonia Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death 2 WKS	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Persistent Vegetative State post CVA Diabetes Mellitus								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Allen J. Gilson MD		29c. License number D26516		29d. Date signed (Month, Day, Year) Dec 18 1998					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Allen J. Gilson MD 1475 TANET NE FRED MD 21702											
31. Date filed (Month, Day, Year) DEC 22 1998		32. Registrar's Signature Benita S. Sparks									

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41152

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>WARNIE JUNIOR LANDIS</b>				2. Date of Death Month <b>DECEMBER</b> Day <b>27</b> , Year <b>1998</b>		3. Time of Death <b>4:30 AM</b>																																		
	4e. Facility Name (If not institution, give street and number) <b>SACRED HEART HOSPITAL</b>				4b. City, Town, or Location of Death <b>CUMBERLAND</b>		4c. County of Death <b>ALLEGANY</b>																																		
Funeral Director	5. Social Security Number <b>234-38-8708</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>70</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>APR. 30, 1928</b>	9. Birthplace (State or Foreign Country) <b>WEST VIRGINIA</b>																																	
	Usual Residence of Decedent				10a. State <b>WV</b>		10b. County <b>MINERAL</b>																																		
To Be Completed by Funeral Director	10c. City, Town or Location <b>FORT ASHBY</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																																				
	10e. Street and Number <b>HC 86, BOX 3</b>				10f. Zip Code <b>26719</b>		10g. Citizen of What Country? <b>U.S.A.</b>																																		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>																																		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>SERVICE REPRESENTATIVE</b>		16b. Kind of Business/Industry <b>1) PETROLEUM CO. 2) SOUTHERN STATES</b>																																				
	17. Father's Name (First, Middle, Last) <b>WARNIE E. LANDIS</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>LENA WAGONER</b>																																				
	19a. Informant's Name/Relationship (Type, Print) <b>HELEN LANDIS / WIFE</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>HC 86, BOX 3 - FORT ASHBY, WV 26719</b>																																				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>FOREST GLEN CEMETERY</b>		Data <b>12/29/98</b>		20c. Location - City or Town, State <b>GREEN SPRING, WV</b>																																		
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>UPCHURCH FUNERAL HOME, INC. P.O. BOX 1260-FORT ASHBY, WV 26719</b>																																				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																																								
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td colspan="6">a. <b>CARCINOMA STOMACH, METASTATIC</b></td> <td rowspan="4">Approximate Interval Between Onset and Death <b>9 MONTHS</b></td> </tr> <tr> <td colspan="6">Due to (or as a consequence of):</td> </tr> <tr> <td colspan="6">b. Due to (or as a consequence of):</td> </tr> <tr> <td colspan="6">c. Due to (or as a consequence of):</td> </tr> <tr> <td colspan="8">           Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a. <b>CARCINOMA STOMACH, METASTATIC</b>						Approximate Interval Between Onset and Death <b>9 MONTHS</b>	Due to (or as a consequence of):						b. Due to (or as a consequence of):						c. Due to (or as a consequence of):						Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						
Immediate Cause (Final disease or condition resulting in death)	a. <b>CARCINOMA STOMACH, METASTATIC</b>						Approximate Interval Between Onset and Death <b>9 MONTHS</b>																																		
	Due to (or as a consequence of):																																								
	b. Due to (or as a consequence of):																																								
	c. Due to (or as a consequence of):																																								
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last																																									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>HYPERTENSION, SUBHYPATIC AND SUBPHRENIC</b> <b>ABCESS, ARTERIOSCLEROSIS</b>																																									
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown																																									
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																																									
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																																									
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																																							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																																			
28d. Describe how injury occurred				28f. Location (Street and Number or Rural Route Number, City or Town, State)																																					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																																									
29b. Signature and title of certifier 				29c. License number <b>D12532</b>		29d. Date signed (Month, Day, Year) <b>DECEMBER 29, 1998</b>																																			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>GEORGE BREZA, M.D., BMG 912 SETON DRIVE, CUMBERLAND, MD 21502</b>																																									
31. Date filed (Month, Day, Year) <b>DEC 30 1998</b>				32. Registrar's Signature 																																					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



United States

For Dr. J. E. Smith

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 41153

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Evelyn M. Lochner

2. Date of Death

Month  
12Day  
21Year  
1998

3. Time of Death

12:20A

4a. Facility Name (If not Institution, give street and number)

Moran manor Nursing Home

4b. City, Town, or Location of Death

Westernport

4c. County of Death

Allegany

Funeral  
Director

5. Social Security Number

216-22-5240

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

9-27-13

9. Birthplace (State or Foreign Country)

WV

Usual Residence of Decedent

10e. State

MD

10b. County

Allegany

10c. City, Town or Location

Westernport

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

25701 Shady Lane SW

10f. Zip Code

21562

10g. Citizen of What Country?

US

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Nursing Assistant

16b. Kind of Business/Industry

Hospital/Nursing Hm

17. Father's Name (First, Middle, Last)

John Cheshire

18. Mother's Name (First, Middle, Maiden Sumama)

Elise (Rigglesman) Cheshire

19a. Informant's Name/Relationship (Type, Print)

Betty Bane/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3 West Frederick Street Piedmont WV 26750

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Philos Cemetery

Date

12-23-98 Westernport MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Wm A. Shroff

22. Name and Address of Facility

Fredlock Funeral Home

P.O. Box 4 31 Jones Street Piedmont WV

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e.

Acute myocardial infarction

30 min

Due to (or as a consequence of):

b.

Congestive heart failure

1 yr.

Due to (or as a consequence of):

c.

Cardiac arrhythmia

1 yr.

Due to (or as a consequence of):

d.

Diabetes mellitus

1 yr.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Osteoarthritis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide8 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Mahesh Shroff M.D.

29c. License number

D-40182

29d. Date signed (Month, Day, Year)

12/23/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Mahesh Shroff MD 390 Carskadon Lane Keyser, WV 26726

31. Date filed (Month, Day, Year)

DEC 29 1998

32. Registrar's Signature

P. Shroff

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41154

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Christina May Llewellyn

2. Date of Death

December 24, 1998

3. Time of Death

5:45 p.m.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Memorial Hospital &amp; Medical Center

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

5. Social Security Number

219-74-9930

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

72

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

April 11, 1926

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Allegany

10c. City, Town or Location

Cumberland

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

Furnace Street Extended

10f. Zip Code

21502

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Navar Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
8College (1-4or 5+)  
016a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

John Russell Llewellyn

18. Mother's Name (First, Middle, Maiden Summa)

Sophia Elizabeth Moreland

19a. Informant's Name/Relationship (Type, Print)

James Llewellyn Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1634 Morning Dove Loop North, Lakeland, FL 33809

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Laurel Hill Cemetery

Date

Dec. 28

20c. Location - City or Town, State

Moscow Mills, MD

21. Signature of Funeral Service Licensee

James E McKenzie

22. Name and Address of Facility

Eichhorn-McKenzie Funeral Home P.A.

8 E. Main Street, Lonaconing, MD 21539

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Acute myocardial infarction, anterior wall

3 days

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Robustiano Barrera

29c. License number

D 14865

29d. Date signed (Month, Day, Year)

December 25, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robustiano Barrera, M.D., Memorial Hospital Medical Building, Cumberland, MD 21502

31. Date filed (Month, Day, Year)

DEC 29 1998

32. Registrar's Signature

P. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Christina Llewellyn

213-09-9871

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41155

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>PAUL VINCENT LEPLEY</b>				2. Date of Death Month <b>Dec</b> 26, Day <b>1998</b> Year		3. Time of Death <b>9:45 pm</b>	
	4a. Facility Name (If not institution, give street and number) <b>213 OAK STREET</b>				4b. City, Town, or Location of Death <b>CUMBERLAND</b>		4c. County of Death <b>ALLEGANY</b>	
Funeral Director	5. Social Security Number <b>213-24-6481</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>69</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Nov 5, 1929</b>	
	9. Birthplace (State or Foreign Country) <b>WV</b>		10a. State <b>MD</b>		10b. County <b>Allegany</b>		10c. City, Town or Location <b>Cumberland</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>213 Oak Street</b>		10f. Zip Code <b>21502</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>Korea</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Ret. Bus Driver</b>		16b. Kind of Business/Industry <b>Bus Company</b>		17. Father's Name (First, Middle, Last) <b>Rister Lepley</b>	
	18. Mother's Name (First, Middle, Maiden Surname) <b>Sarah (Lewis)</b>		19a. Informant's Name/Relationship (Type, Print) <b>Dolores J. Lepley--wife</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>213 Oak Street; Cumberland, MD 21502</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	
Physician /Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) <b>St. Luke's Luth. Cem</b>		20c. Date <b>12/29</b>		20d. Location - City or Town, State <b>Cumberland, MD</b>		21. Signature of Funeral Service Licensee 	
	22. Name and Address of Facility <b>Scarpelli Funeral Home, P.A. Cumberland, MD 21502</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>Arteriosclerotic Heart Disease</b> Due to (or as a consequence of): b. <b>Hyperlipidemia</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death <b>Uk yrs.</b> <b>Uk yrs.</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
Division of Vital Records, P.O. Box 68760,	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal		28a. Date of injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
	29b. Signature and title of certifier 		29c. License number <b>009157</b>		29d. Date signed (Month, Day, Year) <b>Dec 27, 1998</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. Paul Snow; 124 W. Third Street; Cumberland, MD 21502</b>	
State Registrar	31. Date filed (Month, Day, Year) <b>DEC 29 1998</b>		32. Registrar's Signature 		33. Registrar's Title <b>Registrar</b>		34. Registrar's Office <b>State Registrar</b>	





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Anthony J. Lagratta

2. Date of Death

Month Day Year  
Dec. 27, 1998

3. Time of Death

11:11 am

4a. Facility Name (If not institution, give street and number)

Memorial Hospital

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

Funeral  
Director

5. Social Security Number

214-07-6936

8. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

83

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Jan 9, 1915

9. Birthplace (State or Foreign Country)

IN

Usual Residence of Decedent

10a. State

MD

10b. County

Allegany

10c. City, Town or Location

Cumberland

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1315 Michigan Avenue

10f. Zip Code

21502

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates: WW II13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Ret. Spinning Dept.

16b. Kind of Business/Industry

Textile

17. Father's Name (First, Middle, Last)

Orizo Lagratta

18. Mother's Name (First, Middle, Maiden Surname)

Lena (nmn)

19a. Informant's Name/Relationship (Type, Print)

Ella M. Lagratta--wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1315 Michigan Avenue; Cumberland, MD 21502

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Sunset Memorial Park

Date

12/30

20c. Location - City or Town, State

Cumberland, MD

21. Signature of Funeral Service Licensee

Nicholas J. Scarpelli

22. Name and Address of Facility

Scarpelli Funeral Home, P.A.  
Cumberland, MD 2150223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Arteriosclerotic Heart Disease

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Uk yrs

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
2 ☐ Accident investigation  
3 ☐ Suicide 8 ☐ Could not be  
4 ☐ Homicide determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how Injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certificate  
(Check only  
one)1 ☐ Certifying Physician2 ☒ Medical ExaminerTo the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D0957

29d. Date signed (Month, Day, Year)

Dec 27 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Paul Snow; 124 W. Third Street; Cumberland, MD 21502

31. Date filed (Month, Day, Year)

DEC 29 1998

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural," or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
certificate.



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41157

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Glenn E. Landis

2. Date of Death

Dec 23, 1998 Year

3. Time of Death

2:30 am

4a. Facility Name (If not institution, give street and number)

648 Baker Street

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

Funeral  
Director

5. Social Security Number

220-28-9922

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

69 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Feb 20, 1929

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State

MD

10b. County

Allegany

10c. City, Town or Location

Cumberland

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

648 Baker Street

10f. Zip Code

21502

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: Korea13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Retired Cook

16b. Kind of Business/Industry

Food Service

17. Father's Name (First, Middle, Last)

Emmons William Landis

18. Mother's Name (First, Middle, Maiden Summa)

Zella A. (nmn)

19a. Informant's Name/Relationship (Type, Print)

Ruby M. Landis-wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

648 Baker Street Cumberland MD 21502

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Sunset Memorial Park

Date

12/26

20c. Location - City or Town, State

Cumberland MD

21. Signature of Funeral Service Licensee

James J. Scarpelli

22. Name and Address of Facility

Scarpelli Funeral Home, P.A.  
Cumberland MD 2150223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Colon Cancer

Due to (or as a consequence of):

b. Metastases

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) LastApproximate  
Interval Between  
Onset and Death

1 Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation  
6 ☐ Could not be determined28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. W. Guy Fiscus

29c. License number

D12779

29d. Date signed (Month, Day, Year)

12/23/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. W. Guy Fiscus; 500 Memorial Avenue; Cumberland, MD 21502

31. Data filed (Month, Day, Year)

DEC 23 1998

32. Registrar's Signature

B. Fiscus

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MEI GUAN LU					2. Date of Death Month Day Year DEC. 12, 1998		3. Time of Death 11:45 PM		
	4a. Facility Name (If not institution, give street and number) ROCK SPRING ROAD					4b. City, Town, or Location of Death BEL AIR		4c. County of Death HARFORD		
Funeral Director	5. Social Security Number 510-951-346	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 61 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) NOV. 19, 1937		9. Birthplace (State or Foreign Country) CHINA		
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State N/A	10b. Country CANADA		10c. City, Town or Location AGIN COURT, ONTARIO				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number 2 KING LOUIS CRES.			10f. Zip Code M1T2W8		10g. Citizen of What Country? N/A				
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: ASIAN			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CHEF			16b. Kind of Business/Industry RESTAURANT			
	17. Father's Name (First, Middle, Last) UNKNOWN					18. Mother's Name (First, Middle, Maiden Surname) UNKNOWN				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) JIAN YUN ZHANG WIFE					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 KING LOUIS CRES. AGIN COURT, ONTARIO M1T2W8 CANADA				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) HOLLYWOOD MEMORIAL PARK		Date 12/29/98		20c. Location - City or Town, State UNION, NEW JERSEY			
	21. Signature of Funeral Service Licensee <i>Phillip Bell</i>					22. Name and Address of Facility P.O. BOX 26528 CENTRAL VIRGINIA FUNERAL SERVICE RICHMOND, VA				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>MULTIPLE INJURIES</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown									
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	24a. Was an autopsy performed? <i>Insufficient</i> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) AT SCENE				
	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 12 12 98		28b. Time of Injury 2254P M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <i>PEDESTRIAN STRUCK BY CAR</i>	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <i>ROADWAY</i>					28f. Location (Street and Number or Rural Route Number, City or Town, State) <i>ROCK SPRING RD. HARFORD MD</i>				
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
State Registrar	29b. Signature and title of certifier <i>Maureen McShoul</i>					29c. License number O.C.M.E		29d. Date signed (Month, Day, Year) DEC. 13, 1998		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Marysaint D. Kibben</i> 111 Penn Street, Baltimore, Maryland 21201									
31. Date filed (Month, Day, Year) DEC 21 1998					32. Registrar's Signature <i>[Signature]</i>					

Handwritten marks or scribbles.

DEC 1 1936

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 98 41159

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>James Jackson Little</b>				2. Date of Death Month Day Year <b>12-16-98</b>				3. Time of Death <b>8:50 pm</b>	
	4a. Facility Name (If not institution, give street and number) <b>Prince George's Comm. Hospital</b>				4b. City, Town, or Location of Death <b>Cheverly</b>				4c. County of Death <b>Prince George's</b>	
Funeral Director	5. Social Security Number <b>244-40-3147</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (in yrs. last birthday) <b>68</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>8-14-30</b>		9. Birthplace (State or Foreign Country) <b>North Carolina</b>	
	Usual Residence of Decedent									
10a. State <b>Md.</b>		10b. County <b>Prince George's</b>		10c. City, Town or Location <b>Capital Heights</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>617 Larchmont Avenue</b>				10f. Zip Code <b>20743</b>				10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1953</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11th</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Procurement Officer</b>				16b. Kind of Business/Industry <b>Dept. of Navy</b>		
17. Father's Name (First, Middle, Last) <b>Jack Mays</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Louise Little</b>						
19a. Informant's Name/Relationship (Type, Print) <b>Geneva Little, Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>617 Larchmont Ave., Capt., Hgts., Md. 20743</b>						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Maryland Vet. Cem.</b>		20c. Date <b>12-23-98</b>		20d. Location - City or Town, State <b>Cheltenham, Md.</b>				
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Ralph Williams Funeral Service 517 11th St., SE, Wash., DC 20003</b>						
23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
Immediate Cause (Final disease or condition resulting in death)										
a. <b>Coronary Artery Disease</b> Year										
Due to (or as a consequence of):										
b. <b>Diabetes Mellitus</b> Year										
Due to (or as a consequence of):										
c. <b>Hypertensive Cardiovascular Disease</b> Year										
Due to (or as a consequence of):										
d.										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>D14468</b>		29d. Date signed (Month, Day, Year) <b>12/17/98</b>				
30. Name and address of person who completed Cause of death (Item 23e) (Type, Print) <b>Cesar Soriano Jr., MD 119 Capital Hgts. Blvd., Capital Hgts., Md. 20743</b>										
31. Date filed (Month, Day, Year) <b>DEC 21 1998</b>		32. Registrar's Signature 								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

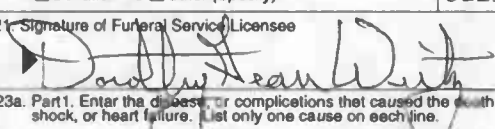
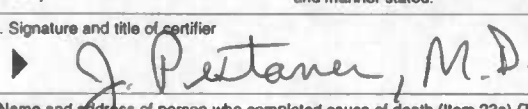





98-7487-033  
crn  
Odell Leonard

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.  
State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

98 41160  
Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Odell Leonard				2. Date of Death Month Day Year December 19, 1998				3. Time of Death 12:48 P.M.			
	4a. Facility Name (If not institution, give street and number) Prince George's Hospital Center				4b. City, Town, or Location of Death Cheverly				4c. County of Death Prince George's			
Funeral Director	5. Social Security Number 250-02-0658		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 44 Yrs.		8. Date of Birth (Month, Day, Year) April 28, 1954		9. Birthplace (State or Foreign Country) South Carolina			
	Usual Residence of Decedent											
To Be Completed by Funeral Director	10a. State Maryland		10b. County Prince George's		10c. City, Town or Location North Brentwood				10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	10e. Street and Number 4606 40th Street				10f. Zip Code 20702		10g. Citizen of What Country? U.S.A.					
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: African-American				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Custodian			16b. Kind of Business/Industry Private Industry				
	17. Father's Name (First, Middle, Last) Frazier Brown				18. Mother's Name (First, Middle, Maiden Surname) Maybelle Leonard							
	19a. Informant's Name/Relationship (Type, Print) Cheryl Leonard - Spouse				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4606 40th Street, North Brentwood, Maryland 20702							
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Guilford Memorial Park		Date 12/23/98		20c. Location - City or Town, State Greenboro, NC					
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death	
	Physician /Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
								24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
	29b. Signature and title of certifier 				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) December 20, 1998					
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201											
	31. Date filed (Month, Day, Year) DEC 23 1998		32. Registrar's Signature 									

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

10

DEC 5 2 1980

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last) **MALINDA A. LIEFER** 2. Date of Death Month **DEC.** Day **20** Year **1998** 3. Time of Death **1:55 AM**

4a. Facility Name (If not institution, give street and number) **NATIONAL LUTHERAN HOME** 4b. City, Town, or Location of Death **ROCKVILLE** 4c. County of Death **MONTGOMERY CO.**

5. Social Security Number **465-56-7885** 6. Sex ☐ M ☒ F 7. Age (In yrs. last birthday) **93** Yrs. 8. Date of Birth (Month, Day, Year) **DEC. 25, 1904** 9. Birthplace (State or Foreign Country) **WISCONSIN**

Usual Residence of Decedent 10a. State **MD.** 10b. County **MONTGOMERY CO.** 10c. City, Town or Location **ROCKVILLE** 10d. Inside City Limits ☒ Yes ☐ No

10e. Street and Number **9701- VEIRS DRIVE** 10f. Zip Code **20850** 10g. Citizen of What Country? **USA**

11. Marital Status ☐ Never Married ☐ Married ☒ Widowed ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? ☐ Yes ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ Yes ☒ No Specify: 14. Race - American Indian, Black, White, etc. Specify: **WHITE**

15. Decedent's Education (Specify only highest grade completed) **12** 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) **OFFICE CLERK** 16b. Kind of Business/Industry **Clerical**

17. Father's Name (First, Middle, Last) **JULIUS LANGE** 18. Mother's Name (First, Middle, Maiden Surname) **DORA BAXMANN**

19a. Informant's Name/Relationship (Type, Print) **REV.DR. REICHARD-EXECUTOR** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) **9701- VEIRS DR., ROCKVILLE, MD. 20850**

20a. Method of Disposition ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) **GREENWOOD MEMORIAL PARK** 20c. Location - City or Town, State **12/24/98-PHOENIX, ARIZONA**

21. Signature of Funeral Service Licensee **W. H. Hysong** 22. Name and Address of Facility **HYSONG CO., INC. 1300- N ST., NW, WASH., DC**

23a. Part I. Enter the disease or condition that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. **Acute Respiratory Failure** **10 minutes**  
Due to (or as a consequence of):  
**Congestive heart failure** **months**  
Due to (or as a consequence of):  
**atrial fibrillation** **years**  
Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? ☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed? ☐ Yes ☒ No 24b. Were autopsy findings available prior to completion of cause of death? ☐ Yes ☒ No

25. Was case referred to medical examiner? ☐ Yes ☒ No 26. Place of Death (Check only one) Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death ☐ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending investigation ☐ Could not be determined 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? ☐ Yes ☒ No 28d. Describe how injury occurred 28e. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier **Charles W. Karesch M.D.** 29c. License number **D21726** 29d. Date signed (Month, Day, Year) **December 20, 1998**

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) **DR. CHARLES W. KARESCH- 9701- VEIRS DR., ROCKVILLE, MD. 20850**

31. Date filed (Month, Day, Year) **DEC 23 1998** 32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

88 41162

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Martha Louise Monn						2. Date of Death Month Day Year Dec. 29. 1998		3. Time of Death 8:25 a.m.																																						
	4a. Facility Name (If not institution, give street and number) Avalon Manor Nursing Home						4b. City, Town, or Location of Death Hagerstown		4c. County of Death Washington																																						
Funeral Director	5. Social Security Number 213-18-9985		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 79 Yrs.		8. Date of Birth (Month, Day, Year) Sept. 7, 1919		9. Birthplace (State or Foreign Country) Maryland																																						
	Usual Residence of Decedent																																														
To Be Completed by Funeral Director	10a. State Maryland		10b. County Washington		10c. City, Town or Location Smithsburg				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																																						
	10e. Street and Number 10 Blue Mountain Estates				10f. Zip Code 21783		10g. Citizen of What Country? USA																																								
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White																																							
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 8				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) homemaker			16b. Kind of Business/Industry home																																							
	17. Father's Name (First, Middle, Last) Franklin A. Mullenix						18. Mother's Name (First, Middle, Maiden Surname) Mary E. Delauter																																								
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Joseph Monn						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Son 21748 Leitersburg Pike Hagerstown, Maryland 21742																																								
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Lawn Memorial Park		Date 12/31/98		20c. Location - City or Town, State Hagerstown, Maryland																																								
	21. Signature of Funeral Service Licensee <i>Gerald N. Minnich</i>				22. Name and Address of Facility Gerald N. Minnich 305 N. Potomac Street Funeral Home Hagerstown, Maryland 21740																																										
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																																														
	<table border="0"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td rowspan="4">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td colspan="8">           e. <i>Recurrent Aspiration Pneumonia</i> Due to (or as a consequence of):         </td> <td>Approximate Interval Between Onset and Death 1 month</td> </tr> <tr> <td colspan="8">           b. <i>Central venous catheter</i> Due to (or as a consequence of):         </td> <td>1 year</td> </tr> <tr> <td colspan="8">c. Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td colspan="8">d. Due to (or as a consequence of):</td> <td></td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death)	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	e. <i>Recurrent Aspiration Pneumonia</i> Due to (or as a consequence of):								Approximate Interval Between Onset and Death 1 month	b. <i>Central venous catheter</i> Due to (or as a consequence of):								1 year	c. Due to (or as a consequence of):									d. Due to (or as a consequence of):							
Immediate Cause (Final disease or condition resulting in death)	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	e. <i>Recurrent Aspiration Pneumonia</i> Due to (or as a consequence of):								Approximate Interval Between Onset and Death 1 month																																					
		b. <i>Central venous catheter</i> Due to (or as a consequence of):								1 year																																					
		c. Due to (or as a consequence of):																																													
		d. Due to (or as a consequence of):																																													
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Dilated cardiomyopathy Anterior wall myocardial infarction</i> <i>Diabetes chronic renal insufficiency</i>								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown																																							
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																																													
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)																																													
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred																																							
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)																																											
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Vasant Datta M. D.</i>		29c. License number D18019		29d. Date signed (Month, Day, Year) Dec 29, 1998																																									
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Vasant Datta M. D., 334 Mill Street Hagerstown, Maryland 21740																																															
31. Date filed (Month, Day, Year) DEC 30 1998		32. Registrar's Signature <i>B. Sparks</i>																																													

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

88 41163

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 2 should be detached for use as the burial-transit

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>GEORGE MANUEL</b>		2. Date of Death Month <b>December</b> Day <b>28</b> Year <b>1998</b>		3. Time of Death <b>3:10 PM</b>	
4a. Facility Name (If not institution, give street and number) <b>Mariner Nursing Home</b>		4b. City, Town, or Location of Death <b>Laurel, Md.</b>		4c. County of Death <b>Prince Georges</b>	
5. Social Security Number <b>214-09-2663</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>79</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>8/20/19</b>		9. Birthplace (State or Foreign Country) <b>Md.</b>
10a. State <b>Md.</b>	10b. County <b>Prince Georges</b>	10c. City, Town or Location <b>Laurel, Md.</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number <b>14200 Laurel Park Drive</b>		10f. Zip Code <b>20707</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status 1 <input type="checkbox"/> Navar Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>0</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Laborer</b>	
16b. Kind of Business/Industry <b>Construction</b>		17. Father's Name (First, Middle, Last) <b>Unknown</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Laura Jones</b>	
19a. Informant's Name/Relationship (Type, Print) <b>Kathleen Watts</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>13609 Avebury Dr. #34 Laurel, Md. 20708</b>			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Cedar Lawn</b>		20c. Location - City or Town, State <b>1/2/99 Hagerstown, Md.</b>	
21. Signature of Funeral Service Licensee <b>Mary Watson</b>		22. Name and Address of Facility <b>Watson Funeral Home 24 W. Bethel St. Hagerstown, Md. 21740</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>hypertension</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>hypertension</b> Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):					Approximate Interval Between Onset and Death <b>2 months</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <b>Andrew Kunz</b>		29c. License number <b>036716</b>		29d. Date signed (Month, Day, Year) <b>December 28, 1998</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Andrew Kunz, MD. 9317 CHERRY LAKE LAUREL, MD.</b>					
31. Date filed (Month, Day, Year) <b>DEC 31 1998</b>		32. Registrar's Signature <b>B. Sparks</b>			

State  
Registrar



RICHARD LEE MCGOWAN

Item: 17 per F.H G-767 1/13/99 reb

**Certificate of Death**

Reg. No.

98 41164

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Richard Lee McGOWAN						2. Date of Death Month Day Year DEC. 23, 1998		3. Time of Death 12:25 AM	
	4a. Facility Name (If not institution, give street and number) 212 EAST AVENUE						4b. City, Town, or Location of Death HAGERSTOWN		4c. County of Death WASHINGTON	
Funeral Director	5. Social Security Number 217-76-8424		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 38 Yrs.		8. Date of Birth (Month, Day, Year) Nov. 17, 1960		9. Birthplace (State or Foreign Country) Illinois	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County Washington		10c. City, Town or Location Hagerstown				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 212 East Avenue				10f. Zip Code 21740		10g. Citizen of What Country? U.S.A.			
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 0-12 College (1-4 or 5+) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) self employed painter				16b. Kind of Business/Industry painter			
	17. Father's Name (First, Middle, Last) UNKNOWN						18. Mother's Name (First, Middle, Maiden Surname) Beverly Hull			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Mrs. Beverly Corbin/mother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 327 Woodpoint Avenue, Hagerstown, Maryland 21740					
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Hagerstown Crematory		Date Dec. 24, 1998		20c. Location - City or Town, State Hagerstown, Maryland			
	21. Signature of Funeral Service Licensee <i>Scott M. Minich</i>				22. Name and Address of Facility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. NARCOTIC AND ETHANOL INTOXICATION Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.									
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown									
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
	24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No									
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No									
	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input checked="" type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) Found: 12-23-98		28b. Time of Injury UNKNOWN M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred UNKNOWN	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) FOUND AT HOME										
28f. Location (Street and Number or Rural Route Number, City or Town, State) 212 EAST AVE. HAGERSTOWN, MD.										
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier <i>J. Pestaner, M.D.</i>				29c. License number O.C.M.E			29d. Date signed (Month, Day, Year) DEC. 23, 1998			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201										
31. Date filed (Month, Day, Year) DEC 28 1998		32. Registrar's Signature <i>B. Sparks</i>								



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

88 41165

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last)

Pauline Daphne MECHLING

2. Date of Death

Month Day Year  
December 22, 1998

3. Time of Death

1:40 a.m.

4a. Facility Name (If not institution, give street and number)

11 W. Baltimore St., Apt. 126

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

5. Social Security Number

220-18-1514

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

93

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
June 18, 1905

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

11 W. Baltimore St., Apt. 126

10f. Zip Code

21740

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

7

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

homemaker

16b. Kind of Business/Industry

her own home

17. Father's Name (First, Middle, Last)

Joseph C. Miller

18. Mother's Name (First, Middle, Maiden Surname)

Lena Kline

19a. Informant's Name/Relationship (Type, Print)

Betty J. Wolfe - daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11 W. Baltimore St., Apt. 126, Hagerstown, Md. 21740

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Rose Hill Cemetery

Date

12-28-98

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee

*Scott M. Minnich*

22. Name and Address of Facility

MINNICH FUNERAL HOME

415 E. Wilson Blvd., Hagerstown, Md. 21740

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Cancer of the colon

Approximate Interval Between Onset and Death

November 95

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

N/A

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*Francisco G. Japson, M.D.*

29c. License number

D05821

29d. Date signed (Month, Day, Year)

12/23/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Francisco G. Japson, M.D., FACS, 346 Mill Street, Hagerstown, Md. 21740

31. Date filed (Month, Day, Year)

DEC 30 1998

32. Registrar's Signature

*B. Sparks*

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 41166

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>JONATHAN BROOK MITCHELL</b>		2. Date of Death Month Day Year <b>December 29, 1998</b>		3. Time of Death <b>3:34 P.M.</b>	
4a. Facility Name (If not Institution, give street and number) <b>Atlantic Ocean, 6 miles east of Ocean City</b>		4b. City, Town, or Location of Death <b>Ocean City</b>		4c. County of Death <b>Worcester</b>	
5. Social Security Number <b>214-08-0127</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>28</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>11-28-70</b>	9. Birthplace (State or Foreign Country) <b>MD.</b>	
Usual Residence of Decedent					
10a. State <b>MD.</b>		10b. County <b>WORCESTER</b>		10c. City, Town or Location <b>OCEAN CITY</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number <b>9623 W. FOURTH STREET</b>		10f. Zip Code <b>21842</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>FISHERMAN</b>		16b. Kind of Business/Industry <b>COMMERCIAL FISHING</b>	
17. Father's Name (First, Middle, Last) <b>ROBERT MITCHELL</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>JOANN WILLIAMS</b>			
19a. Informant's Name/Relationship (Type, Print) <b>AMY S. MITCHELL SPOUSE</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9623 W. 4TH STREET, OCEAN CITY, MD., 21842</b>			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>SALISBURY CREAMTORY</b>		20c. Location - City or Town, State <b>12-31 SALISBURY, MD.</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>ULLRICH FUNERAL HOME BERLIN, MD, 21811</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death) <b>a. Hypothelmin</b> Due to (or as a consequence of):					
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b.</b> Due to (or as a consequence of):					
<b>c.</b> Due to (or as a consequence of):					
<b>d.</b>					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>subject on boat</b>			
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) <b>12/28/98</b>		28b. Time of Injury <b>12:32</b> M	
		28c. Injury at Work? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred <b>partially sank, entered water and exposed to cold weather</b>	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>Ocean</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>6 miles east of Ocean City, Maryland</b>	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>O.C.M.E.</b>	
		29d. Date signed (Month, Day, Year) <b>December 30, 1998</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201</b>					
31. Date filed (Month, Day, Year) <b>DEC 31 1998</b>		32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

10

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41167

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

PETER PRETTYMAN MASON, JR.

2. Date of Death

Month Day Year  
DEC 27 1998

3. Time of Death

6:00 AM

4a. Facility Name (If not institution, give street and number)

NATIONAL NAVAL MEDICAL CENTER

4b. City, Town, or Location of Death

BETHESDA

4c. County of Death

MONTGOMERY

5. Social Security Number

215-14-3441

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

75

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
11/5/23

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Worcester

10c. City, Town or Location

Snow Hill

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5952 Basketwitch Road

10f. Zip Code

21863

10g. Citizen of What Country?

U.S.A,  
Worcester Cty.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☐ No  
If Yes, Give Year or Dates: 1940-

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

Collage (1-4or 5+)

16a. Decedant's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Maintenance Work

16b. Kind of Business/Industry

Ocean City  
Condominium Assoc.

17. Father's Name (First, Middle, Last)

Peter Prettyman Mason, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Annie Payne (Mason)

19a. Informant's Name/Relationship (Type, Print)

M. Margaret Mason

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5952 Basketwitch Rd., Snow Hill, Md. 21863

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Md. Veteran's Cemetery

Date

12/31

20c. Location - City or Town, State

Hurlock, Md.

21. Signature of Funeral Service Licensee

Patricia L. Dennis

22. Name and Address of Facility

Dennis Funeral Home, Snow Hill, Md. 21863

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

ESOPHAGEAL CANCER

Approximate  
Interval Between  
Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

2 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

28. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Medical Examiner2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Jeffrey Tjaden M.D.

29c. License number

8294 (MT)

29d. Date signed (Month, Day, Year)

Dec, 28, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JEFFREY TJADEN, LT, MC, USNR

NATIONAL NAVAL MEDICAL CENTER

BETHESDA MD 20889-5600

31. Date filed (Month, Day, Year)

DEC 29 1998

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

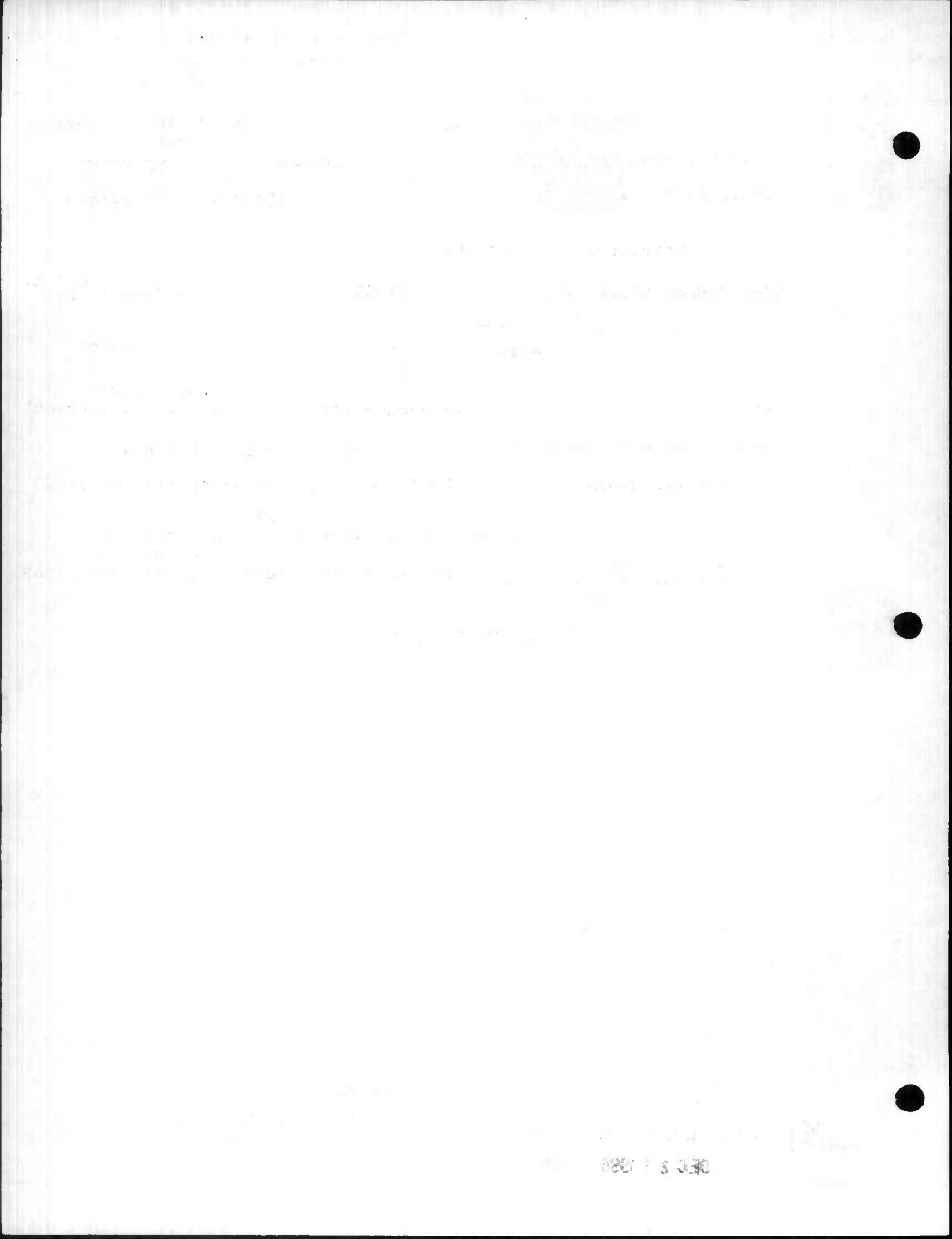
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 41168

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) <b>Theodore Messick</b>				2. Date of Death Month <b>12</b> Day <b>26</b> Year <b>98</b>		3. Time of Death <b>0025</b>	
4a. Facility Name (If not institution, give street and number) <b>PENINSULA REGIONAL MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>SALISBURY</b>		4c. County of Death <b>WICOMICO</b>	
5. Social Security Number <b>222-10-2910</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>84</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Sept 5, 1914</b>	
9. Birthplace (State or Foreign Country) <b>Delaware</b>							
10a. State <b>DE</b>				10b. County <b>Sussex</b>		10c. City, Town or Location <b>Laurel</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
10e. Street and Number <b>Rd 4 Box 73</b>				10f. Zip Code <b>19956</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WW II</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Store Clerk</b>		16b. Kind of Business/Industry <b>Nylon Company</b>	
17. Father's Name (First, Middle, Last) <b>Charles W. Messick</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Ethel Hastings Messick</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Janet Messick Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Rd 4 Box 73 Laurel, DE 19956</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Odd Fellows Cemetery</b>		Date <b>12-29-98</b>		20c. Location - City or Town, State <b>Laurel, Delaware</b>	
21. Signature of Funeral Service Licensee <b>William M. Smith</b>				22. Name and Address of Facility <b>Short Funeral Home 700 West Street Laurel, DE 19956</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Esophageal Cancer</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>						Approximate Interval Between Onset and Death <b>3 months</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier <b>David E. Carroll MD</b>				29c. License number <b>D26278</b>		29d. Date signed (Month, Day, Year) <b>12-26-98</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>David E. Carroll, MD 145 E. Carroll St. Salisbury, MD 21801</b>							
31. Date filed (Month, Day, Year) <b>DEC 29 1998</b>				32. Registrar's Signature <b>[Signature]</b>			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Theodore Messick  
222-10-2910  
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

Amended Item #20b per F.D. 12/28/98 Carroll Co. **Certificate of Death**

Reg. No.

98 41169

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Pauline E. Muller</b>						2. Date of Death Month Day Year <b>December 24, 1998</b>		3. Time of Death <b>1:40 P.M.</b>			
	4a. Facility Name (If not institution, give street and number) <b>5908 Grace Lee Avenue</b>						4b. City, Town, or Location of Death <b>Sykesville</b>		4c. County of Death <b>Carroll</b>			
Funeral Director	5. Social Security Number <b>212-24-6289</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>71</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Nov. 16, 1927</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>			
	Usual Residence of Decedent											
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>Carroll</b>		10c. City, Town or Location <b>Sykesville</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	10e. Street and Number <b>5908 Grace Lee Ave.</b>				10f. Zip Code <b>21784</b>		10g. Citizen of What Country? <b>United States</b>					
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7th grade</b> College (1-4 or 5+) _____		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Owner</b>				16b. Kind of Business/Industry <b>Mullers Grocery Store</b>					
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>Charles E. Hoff, Sr.</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Hilda M. Niner</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Hobart Muller Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>396 Rife Road East Berlin, PA 17316</b>							
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Salem Church Cemetery</b>		Date performed <b>12/28/98</b>		20c. Location - City or Town, State <b>Westminster, Maryland</b>					
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Burrier-Queen Funeral Directors, P.A. 1212 W. Old Liberty Road Winfield, MD 21784</b>							
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Hypertensive Arteriosclerotic Cardiovascular Disease</b> a. Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
											24a. Was an autopsy performed? <b>Inspection</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
											24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred			
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
State Registrar	29b. Signature and title of certifier 				29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>December 27, 1998</b>					
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Stephen Radentz, M.D. 111 Penn Street, Baltimore, Maryland 21201</b>											
	31. Date filed (Month, Day, Year) <b>DEC 28 1998</b>		32. Registrar's Signature 									

ORIGINAL





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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Nema (First, Middle, Last) <b>FLORA ALICE RODKEY MORELOCK</b>				2. Date of Death Month <b>DECEMBER</b> Day <b>23</b> , Year <b>1998</b>		3. Time of Death <b>6:55 PM</b>														
	4a. Facility Nema (If not institution, give street and number) <b>WESTMINSTER NURSING &amp; REHAB. CENTER</b>				4b. City, Town, or Location of Death <b>WESTMINSTER</b>		4c. County of Death <b>CARROLL</b>														
Funeral Director	5. Social Security Number <b>213-01-3146</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>83</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>JAN. 10, 1915</b>														
	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>		10a. State <b>MARYLAND</b>		10b. County <b>CARROLL</b>		10c. City, Town or Location <b>WESTMINSTER</b>														
To Be Completed by Funeral Director	Usual Residence of Decedent				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																
	10e. Street and Number <b>2516 TYRONE ROAD</b>				10f. Zip Code <b>21158</b>		10g. Citizen of What Country? <b>UNITED STATES</b>														
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>														
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>1</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>FACTORY WORKER</b>		16b. Kind of Business/Industry <b>BLACK AND DECKER MANUFACTURING CO.</b>																
	17. Father's Nema (First, Middle, Last) <b>HOWARD M. RODKEY</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>EMMA M. KRENZER</b>																
	19a. Informant's Name/Relationship (Type, Print) <b>DOTTY M. WADDELL / DAUGHTER</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2522 TYRONE ROAD WESTMINSTER, MD. 21158</b>																
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>EMMANUEL CEMETERY (BAUST) U.C.C.</b>		Date <b>DEC. 28 1998</b>		20c. Location - City or Town, State <b>WESTMINSTER, MARYLAND</b>														
	21. Signature of Funeral Service Licensee <b>MO1072</b> <i>Man C. Davis</i>		22. Name and Address of Facility <b>SKILES FUNERAL HOME</b> <b>136 E. BALTIMORE STREET TANEYTOWN, MD. 21787</b>																		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																				
	<table border="0"> <tr> <td rowspan="4">                 Immediata Cause (Final disease or condition resulting in death)                   Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last             </td> <td>a.</td> <td><i>Pneumonia</i></td> <td>Due to (or as a consequence of):</td> <td rowspan="4">                 Approximate Interval Between Onset and Death   <i>1 wk</i>   <i>5 yr</i> </td> </tr> <tr> <td>b.</td> <td><i>Alzheimer's</i></td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>c.</td> <td></td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> <td></td> <td>Due to (or as a consequence of):</td> </tr> </table>								Immediata Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a.	<i>Pneumonia</i>	Due to (or as a consequence of):	Approximate Interval Between Onset and Death  <i>1 wk</i>  <i>5 yr</i>	b.	<i>Alzheimer's</i>	Due to (or as a consequence of):	c.		Due to (or as a consequence of):	d.	
Immediata Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a.	<i>Pneumonia</i>	Due to (or as a consequence of):	Approximate Interval Between Onset and Death  <i>1 wk</i>  <i>5 yr</i>																	
	b.	<i>Alzheimer's</i>	Due to (or as a consequence of):																		
	c.		Due to (or as a consequence of):																		
	d.		Due to (or as a consequence of):																		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown															
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No															
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No															
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)																			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No															
		28d. Describe how Injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)																	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>John Middleton</i>		29c. License number <b>D25443</b>		29d. Date signed (Month, Day, Year) <b>12/24/98</b>															
30. Nema and address of person who completed cause of death (Item 23e) (Type, Print) <b>JOHN MIDDLETON, M.D.</b> <b>1688 Poole Road Westminister Snd 21157</b>																					
31. Date filed (Month, Day, Year) <b>DEC 28 1998</b>		32. Registrar's Signature <i>B. Sparks</i>																			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **98 41171**  
**Certificate of Death**

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last) **KATHRYN ANITA MICHAEL** 2. Date of Death Month **DEC.** Day **14,** Year **1998** 3. Time of Death **9:50 PM.**

Funeral  
Director

4a. Facility Name (If not institution, give street and number) **WESTMINSTER NURSING HOME** 4b. City, Town, or Location of Death **WESTMINSTER** 4c. County of Death **CARROLL**

5. Social Security Number **216-46-6184** 6. Sex ☐ M ☒ F 7. Age (In yrs. last birthday) **95** Yrs. If Under 1 Year Months Days If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) **3/29/1903** 9. Birthplace (State or Foreign Country) **MARYLAND**

Usual Residence of Decedent 10a. State **MD.** 10b. County **BALTIMORE** 10c. City, Town or Location **COCKEYSVILLE** 10d. Inside City Limits ☐ Yes ☒ No

10e. Street and Number **5 SPRING GLEN COURT** 10f. Zip Code **21030** 10g. Citizen of What Country? **USA.**

11. Marital Status ☐ Never Married ☐ Married ☒ Widowed ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? ☐ Yes ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ Yes ☒ No Specify: 14. Race - American Indian, Black, White, etc. Specify: **WHITE**

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) **7** College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) **HOUSEWIFE** 16b. Kind of Business/Industry **HOME MAKING**

17. Father's Name (First, Middle, Last) **EDWARD L. DOUGHERTY** 18. Mother's Name (First, Middle, Maiden Surname) **BESSIE ANITA RITTER**

19a. Informant's Name/Relationship (Type, Print) **STANLEY MICHAEL, JR.-SON** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) **5 SPRING GLEN CT., COCKEYSVILLE, MD. 21030**

20a. Method of Disposition ☐ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☒ Other (Specify) **ENTOMBMENT** 20b. Place of Disposition (Name of cemetery, crematory or other place) **LORRAINE PARK CEM.** Date **12/17/98** 20c. Location - City or Town, State **BALTIMORE, MD.**

21. Signature of Funeral Service Licensee **R. Lang** 22. Name and Address of Facility **FLETCHER FUNERAL HOME** **254 E. MAIN ST., WESTMINSTER, MD. 21157**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Respiratory Failure** Due to (or as a consequence of): **Myocardial Valve Stenosis**

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last **1 week**  
**5 years**

23b. Did tobacco use contribute to the cause of death? ☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed? ☐ Yes ☒ No 24b. Were autopsy findings available prior to completion of cause of death? ☐ Yes ☒ No

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. **Dementia**  
**Coronary Artery Disease**

25. Was case referred to medical examiner? ☐ Yes ☒ No 26. Place of Death (Check only one) Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death ☒ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending investigation ☐ Could not be determined 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? ☐ Yes ☒ No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier **Paul E. Forest** 29c. License number **D33281** 29d. Date signed (Month, Day, Year) **12/21/98**

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) **Paul E. Forest, MD** **912 Washington Rd Westminister, Md**  
**2157**

31. Date filed (Month, Day, Year) **DEC 28 1998** 32. Registrar's Signature **B. Sparks**

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41172

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Charlotte Elaine McCollister

2. Date of Death

Month  
Dec.Day  
32Year  
1998

3. Time of Death

1900

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

5. Social Security Number

025-20-2430

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

71

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
April 11, 1927

9. Birthplace (State or Foreign Country)

Mass.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Dorchester

10c. City, Town or Location

Cambridge

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

3220 Indian Bone Road

10f. Zip Code

21613

10g. Citizen of What Country?

US

11. Marital Status

1 ☐ Never Married ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Ted Brusso

18. Mother's Name (First, Middle, Maiden Surname)

Laura Love

19a. Informant's Name/Relationship (Type, Print)

Granville F. McCollister Husband 3220 Indian Bone Road Cambridge, Maryland 21613

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Green Lawn Cemetery

Date

12/27

20c. Location - City or Town, State

Cambridge, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Thomas Funeral Home, P.A.  
700 Locust Street Cambridge, Maryland 21613

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Pneumonia*

Due to (or as a consequence of):

b. *Neutropenic post chemotherapy*

Due to (or as a consequence of):

c. *metastatic lymphoma*

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

*Weeks**Months*

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D39813

29d. Date signed (Month, Day, Year)

12/23/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

my address 1104 Westbury Ave Salisbury MD 21804

31. Date filed (Month, Day, Year)

DEC 29 1998

32. Registrar's Signature

State  
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.









Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41174

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>Norma Jean Miller</b>				2. Date of Death Month <b>December</b> Day <b>23</b> Year <b>1998</b>		3. Time of Death <b>08:20 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>20503 Klondike Road, S.W.</b>				4b. City, Town, or Location of Death <b>Klondike</b>		4c. County of Death <b>Allegany</b>		
<b>Funeral Director</b>	5. Social Security Number <b>213-24-5803</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>70</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>18-May-28</b>		
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10. Usual Residence of Decedent		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		
<b>To Be Completed by Funeral Director</b>	10a. State <b>Maryland</b>		10b. County <b>Allegany</b>		10c. City, Town or Location <b>Frostburg</b>		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number <b>20503 Klondike Road, S.W.</b>				10f. Zip Code <b>21532-</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
	11. Merital Status		12. Was Decedent Ever In U.S. Armed Forces?		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)		14. Race - American Indian, Black, White, etc. Specify <b>White</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Homemaker</b>				
	17. Father's Name (First, Middle, Last) <b>William Yantz</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Alberta Schell</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>Dale Miller Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>20503 Klondike Road, S.W. Frostburg Maryland 21532-</b>				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Frostburg Memorial Park</b>		20c. Location - City or Town, State <b>27-Dec-98 Frostburg, Maryland</b>				
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532</b>				
	23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. <b>Lung CA</b> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death <b>1 month</b>	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
							24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
							24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>D 28910</b>		29d. Date signed (Month, Day, Year) <b>Dec. 28, 1998</b>			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>H. Curtis Merrick, 500 Memorial Avenue, Cumberland, Maryland 21502</b>									
31. Date filed (Month, Day, Year) <b>DEC 28 1998</b>		32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532

Frostburg Memorial Park 27-Dec-98 Frostburg, Maryland

Dale Miller son 20503 Klondike Road, S.W. Frostburg Maryland 21532-

William Yantz

Alberta Schell

12 0 Homemaker Homemaker

Wife

21532- U.S.A.

20503 Klondike Road, S.W.

Maryland Allegany Frostburg

213-24-2803 70 18-May-58 Maryland

20503 Klondike Road, S.W.

Klondike

Allegany

Norma Jean Miller

December

22 1998

MA 09:30 AM

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 41175

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ELMER MOTHERSHEAD</b>				2. Date of Death Month Day Year <b>DEC 17 1998</b>		3. Time of Death <b>4:10 PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>SOUTHERN MARYLAND HOSPITAL CENTER</b>				4b. City, Town, or Location of Death <b>CLINTON</b>		4c. County of Death <b>PRINCE GEORGE'S</b>		
Funeral Director	5. Social Security Number <b>578 05 2334</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>94</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>March 19, 1904</b>		
	9. Birthplace (State or Foreign Country) <b>Washington DC</b>		10e. State <b>MD</b>		10b. County <b>P.G.</b>		10c. City, Town or Location <b>Forestville</b>		
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>7502 Marion Street</b>		10f. Zip Code <b>20747</b>		10g. Citizen of What Country? <b>United States</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Confectionary Worker</b>		16b. Kind of Business/Industry <b>Bakery Industry</b>		17. Father's Name (First, Middle, Last) <b>William Mothershead</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Betty Coats</b>	
19a. Informant's Name/Relationship (Type, Print) <b>Ellen Suthard (Daughter)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4175 Fox Run Lane, Huntingtown, Maryland 20639</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Cedar Hill Cemetery</b>		20c. Location - City or Town, State <b>Dec 21, 1998 Suitland, Maryland</b>	
21. Signature of Funeral Service Licensee		22. Name and Address of Facility <b>Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>RENAL FAILURE</b> Due to (or as a consequence of): <b>METASTATIC PROSTATE CANCER</b> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>5 YEARS</b>		Approximate Interval Between Onset and Death <b>4 DAYS</b>			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <b>DEC 18 1998</b>		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Vincent Chen</b>		29c. License number <b>D38129</b>		29d. Date signed (Month, Day, Year) <b>DEC 18 1998</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>VINCENT CHEN, MD 9131 PISCATAWAY RD #600 CLINTON, MD 20735</b>		31. Data filed (Month, Day, Year) <b>DEC 22 1998</b>		32. Registrar's Signature <b>B. Sparks</b>					

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 41176  
Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ANNA ESTELLE MC COLLEY

2. Date of Death

Month Day Year  
DECEMBER 18, 1998

3. Time of Death

5:15 AM

Funeral  
Director

4a. Facility Name (If not Institution, give street and number)

St. Mary's Hospital

4b. City, Town, or Location of Death

Leonardtown

4c. County of Death

ST. MARY'S

5. Social Security Number

579 22 3579

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

101 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Dec 10, 1897

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

St. Mary's

10c. City, Town or Location

Mechanicsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

28625 Hancock Drive

10f. Zip Code

20659

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Clerk

16b. Kind of Business/Industry

Printers

17. Father's Name (First, Middle, Last)

William Edward Johnson

18. Mother's Name (First, Middle, Maiden Surname)

Mary E. Johnson

19a. Informant's Name/Relationship (Type, Print)

James W. Barry, Sr. (SON IN LAW) 28625 Hancock Drive, Mechanicsville, MD 20659

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arlington National Cemetery

Dec 23, 1998

20c. Location - City or Town, State

Arlington, Virginia

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

12/17/98

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License Number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

DEC 22 1998

32. Registrar's Signature

Hollywood 1222

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41177

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Thomas C. Masano

2. Date of Death

Dec 10, 1998

3. Time of Death

7:55 A.M.

4a. Facility Name (If not institution, give street and number)

Southern Maryland Hosptial

4b. City, Town, or Location of Death

Clinton

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

579 38 2798

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

68

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Jan 1, 1930

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

P.G.

10c. City, Town or Location

Clinton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7702 Don Drive

10f. Zip Code

20735

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No  
Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Artisan

16b. Kind of Business/Industry

Woodworking / Self

Employed

17. Father's Name (First, Middle, Last)

Comedo Masano

18. Mother's Name (First, Middle, Maiden Surname)

Angelina Brugulio

19a. Informant's Name/Relationship (Type, Print)

Marlene Masano

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7702 Don Drive, Clinton, Maryland 20735

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Lee Crematory Dec 13, 1998

Date

20c. Location - City or Town, State

Clinton, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Lee Funeral Home, Inc 6633 Old  
Alexandria Ferry Road, Clinton, Maryland 2073523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a.

Arrhythmia

Due to (or as a consequence of):

b.

Cardiomyopathy

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) LastApproximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ NoHospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D 1261

29d. Date signed (Month, Day, Year)

Dec 12, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kenneth T., Larsen, Jr. 7503 Surratts Road, EM Dept, Clinton, Maryland 20735

31. Date filed (Month, Day, Year)

DEC 22 1998

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar



RODERICK A. MATHIS

ITEMS: #23 PART 1, 27, 28A-F PERMED G76

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41178

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

RODERICK A. MATHIS

2. Date of Death

Month Day Year  
DEC. 28, 1998

3. Time of Death

1815 PM

4a. Facility Name (If not institution, give street and number)

16002 EASTINGS COURT-B

4b. City, Town, or Location of Death

BOWIE

4c. County of Death

PRINCE GEORGES

Funeral  
Director

5. Social Security Number

579-82-1650

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

35 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
May 30, 1963

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Bowie

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

16002 Eastings Court, Apt #B

10f. Zip Code

20716

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No 04/1984  
If Yes, Give  
Year or Dates: 08/198413. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Office Assistant

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Albert R. Mathis

18. Mother's Name (First, Middle, Maiden Surname)

Veola Ervin

19a. Informant's Name/Relationship (Type, Print)

Veola E. Mathis/Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5706 K Street, Fairmont Heights, Maryland 20743

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Harmony Memorial Park

Date

01/04  
1999

20c. Location - City or Town, State

Landover, Maryland

21. Signature of Funeral Service Licensee

Nancy A. Perante

22. Name and Address of Facility

J. B. JENKINS FUNERAL HOME  
7474 Landover Road, Landover, Maryland 2078523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. FOCAL MYOCARDIAL FIBROSIS COMPLICATED BY COCAINE ABUSE

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)

Found-28-98

28b. Time of  
InjuryFound: 3:14  
P M28c. Injury at  
Work?1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

UNKNOWN

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

FOUND: RESIDENCE

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)

16002 EASTINGS CT-B

BOWIE, MARYLAND

29a. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Nancy A. Perante

29c. License number

O.C.M.E

29d. Date signed (Month, Day, Year)

DEC. 29, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Roderick A. Mathis 111 Penn Street, Baltimore, Maryland 21201

State  
Registrar

31. Date filed (Month, Day, Year)

JAN 04 1999

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

ITEMS: #17, 19B PER INFORMANT G769 3-26-99 WR.  
Amend # 2. Per Phys. PGC 12-21-98 cr

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41179

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>La Voigne</b>				2. Date of Death Month <b>Dec</b> Day <b>13</b> Year <b>1998</b>				3. Time of Death <b>5:55 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>13125 Greenmount Avenue</b>				4b. City, Town, or Location of Death <b>Beltsville</b>				4c. County of Death <b>Prince George's</b>	
Funeral Director	5. Social Security Number <b>578-50-9215</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>61</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>September 6, 1937</b>		9. Birthplace (State or Foreign Country) <b>Washington, D.C.</b>	
	Usual Residence of Decedent									
10a. State <b>Maryland</b>		10b. County <b>Prince George's</b>		10c. City, Town or Location <b>Beltsville</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>13125 Greenmount Avenue</b>				10f. Zip Code <b>20705</b>				10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2 years</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Financial Specialist</b>				16b. Kind of Business/Industry <b>Private</b>		
17. Father's Name (First, Middle, Last) <b>Oscar McDaniels</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Margaret Lyles</b>						
19a. Informant's Name/Relationship (Type, Print) <b>Ursula Epps/Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8910 Trepper Court, Adelphi, Maryland 20783</b>						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Harmony Memorial Park</b>				20c. Location - City or Town, State <b>Landover, Maryland</b>		
21. Signature of Funeral Service Licensee <b>Nancy A. Perconte</b>				22. Name and Address of Facility <b>J. B. JENKINS FUNERAL HOME 7474 Landover Road, Landover, Maryland 20785</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. METASTATIC ROM CARCINOMA</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>								Approximate Interval Between Onset and Death <b>12 mo.</b>		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
								24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
				28d. Describe how injury occurred				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <b>[Signature]</b>				29c. License number <b>D29675</b>		
				29d. Date signed (Month, Day, Year) <b>Dec 15, 1998</b>						
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) <b>Rose Boccia MD 9707 Mexico Center Dr, Beltsville, MD</b>										
31. Date filed (Month, Day, Year) <b>DEC 21 1998</b>				32. Registrar's Signature <b>[Signature]</b>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41180

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>LUCY BRUMFIELD McDUFFIE</b>						2. Date of Death Month Day Year <b>DECEMBER 15, 1998</b>		3. Time of Death <b>8:00 PM</b>																				
	4a. Facility Name (If not institution, give street and number) <b>HOLY CROSS HOSPITAL</b>						4b. City, Town, or Location of Death <b>SILVER SPRING</b>		4c. County of Death <b>MONTGOMERY COUNTY</b>																				
Funeral Director	5. Social Security Number <b>578-28-9051</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>72</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>JAN. 19, 1926</b>		9. Birthplace (State or Foreign Country) <b>MARYLAND</b>																				
	Usual Residence of Decedent																												
To Be Completed by Funeral Director	10a. State <b>MARYLAND</b>		10b. County <b>PRINCE GEORGE'S</b>		10c. City, Town or Location <b>GLENARDEN</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																				
	10e. Street and Number <b>7932 GLENARDEN PARKWAY, #423</b>				10f. Zip Code <b>20706</b>		10g. Citizen of What Country? <b>UNITED STATES</b>																						
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>																					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>CLERK</b>			16b. Kind of Business/Industry <b>FEDERAL GOVERNMENT</b>																					
	17. Father's Name (First, Middle, Last) <b>REUBEN BRUMFIELD</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>AGNES MEYERS</b>																						
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>EUGENE R. McDUFFIE, III, SON</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10509 THRIFT ROAD, CLINTON, MARYLAND 20735</b>																						
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>FORT LINCOLN CEMETERY</b>		Date <b>12/21/98</b>		20c. Location - City or Town, State <b>BRENTWOOD, MARYLAND</b>																						
	21. Signature of Funeral Service Licensee <i>[Signature]</i>						22. Name and Address of Facility <b>FORT LINCOLN FUNERAL HOME 3401 BLADENSBURG RD., BRENTWOOD, MARYLAND 20722</b>																						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																												
	<table border="0"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a.</td> <td><b>pneumonia</b></td> <td rowspan="4">Approximate Interval Between Onset and Death</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td>b.</td> <td><b>cerebrovascular accident</b></td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td rowspan="4">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>c.</td> <td><b>atrial fibrillation</b></td> <td rowspan="4">years</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> <td></td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death)	a.	<b>pneumonia</b>	Approximate Interval Between Onset and Death	Due to (or as a consequence of):		b.	<b>cerebrovascular accident</b>	Due to (or as a consequence of):		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	<b>atrial fibrillation</b>	years	Due to (or as a consequence of):		d.		Due to (or as a consequence of):
Immediate Cause (Final disease or condition resulting in death)	a.	<b>pneumonia</b>	Approximate Interval Between Onset and Death																										
	Due to (or as a consequence of):																												
	b.	<b>cerebrovascular accident</b>																											
	Due to (or as a consequence of):																												
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	<b>atrial fibrillation</b>	years																										
	Due to (or as a consequence of):																												
	d.																												
	Due to (or as a consequence of):																												
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>necrotizing fasciitis</b> <b>massive decubitus ulcer</b> <b>diabetes mellitus</b>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown																					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No																											
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																											
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred																					
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)																					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																													
29b. Signature and title of certifier <i>[Signature]</i>				29c. License number <b>A34590</b>			29d. Date signed (Month, Day, Year) <b>12-16-98</b>																						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Roy Fried. MD, Kaiser Office, Holy Cross Hospital, address in item 4, above</b>																													
31. Date filed (Month, Day, Year) <b>DEC 21 1998</b>		Registrar's Signature <i>[Signature]</i>																											

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



00013030

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41181

**Physician /Medical Examiner**

**Funeral Director**

**To Be Completed by Funeral Director**

**To Be Completed by Physician/Medical Examiner**

**Physician /Medical Examiner**

**Division of Vital Records, P.O. Box 68760,**

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

(2)

**State Registrar**

1. Decedent's Name (First, Middle, Last) <b>John Fitzgerald Martin</b>				2. Date of Death Month <b>December</b> Day <b>17</b> Year <b>1998</b>		3. Time of Death <b>8:45 A.M.</b>																							
4a. Facility Name (If not institution, give street and number) <b>908 Marcy Avenue, Apt. P-3</b>				4b. City, Town, or Location of Death <b>Oxon Hill</b>		4c. County of Death <b>Prince Georges</b>																							
5. Social Security Number <b>578-02-4532</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>34</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>1964</b>	9. Birthplace (State or Foreign Country) <b>Washington, D.C.</b>																						
Usual Residence of Decedent																													
10a. State <b>Maryland</b>		10b. County <b>Prince Georges</b>		10c. City, Town or Location <b>Oxon Hill</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No																							
10e. Street and Number <b>908 Marcy Avenue, Apt. P-3</b>				10f. Zip Code <b>20745</b>		10g. Citizen of What Country? <b>United States</b>																							
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>																							
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th grade</b>		College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Maintenance Worker</b>		16b. Kind of Business/Industry <b>Avis Car Rental</b>																							
17. Father's Name (First, Middle, Last) <b>John Eddie Martin</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Parthenia Hamm</b>																									
19a. Informant's Name/Relationship (Type, Print) <b>John E. Martin (Father)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3200 "E" Street, S.E.; Apt. 1F; Washington, D.C. 20019</b>																									
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Forest Hills Memorial Gardens</b>		Date <b>Dec. 22, 1998</b>		20c. Location - City or Town, State <b>Clinton, Maryland</b>																							
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Robert G. Mason Funeral Home, Inc. 1661 Good Hope Road, S.E.; Washington, D.C. 20020</b>																									
23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																													
<table border="0"> <tr> <td rowspan="4"> <b>Immediate Cause (Final disease or condition resulting in death)</b>   <b>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</b> </td> <td>a.</td> <td><b>Right Heart Congestive Heart Failure</b></td> <td rowspan="4"> <b>Approximate Interval Between Onset and Death</b> </td> </tr> <tr> <td></td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>b.</td> <td><b>Morbid Exogenous Obesity</b></td> </tr> <tr> <td></td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td></td> <td>c.</td> <td><b>Chronic Obstructive Lung Disease</b></td> <td></td> </tr> <tr> <td></td> <td></td> <td>Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td></td> <td>d.</td> <td></td> <td></td> </tr> </table>								<b>Immediate Cause (Final disease or condition resulting in death)</b>  <b>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</b>	a.	<b>Right Heart Congestive Heart Failure</b>	<b>Approximate Interval Between Onset and Death</b>		Due to (or as a consequence of):	b.	<b>Morbid Exogenous Obesity</b>		Due to (or as a consequence of):		c.	<b>Chronic Obstructive Lung Disease</b>				Due to (or as a consequence of):			d.		
<b>Immediate Cause (Final disease or condition resulting in death)</b>  <b>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</b>	a.	<b>Right Heart Congestive Heart Failure</b>	<b>Approximate Interval Between Onset and Death</b>																										
		Due to (or as a consequence of):																											
	b.	<b>Morbid Exogenous Obesity</b>																											
		Due to (or as a consequence of):																											
	c.	<b>Chronic Obstructive Lung Disease</b>																											
		Due to (or as a consequence of):																											
	d.																												
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. <b>Pulmonary Hypertension</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown																							
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																							
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																											
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																							
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred																									
28f. Location (Street and Number or Rural Route Number, City or Town, State)																													
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																													
29b. Signature and title of certifier 				29c. License number <b>D0051913</b>		29d. Date signed (Month, Day, Year) <b>December 18, 1998</b>																							
30. Name and address of person completing cause of death (Item 23a) (Type, Print) <b>Bejkeni, S. CHARLES H.</b>				<b>6196 Oxon Hill Road, Suite 240 Oxon Hill, Maryland 20745</b>																									
31. Date filed (Month, Day, Year) <b>DEC 23 1998</b>				32. Registrar's Signature 																									

DEC 3 1934

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

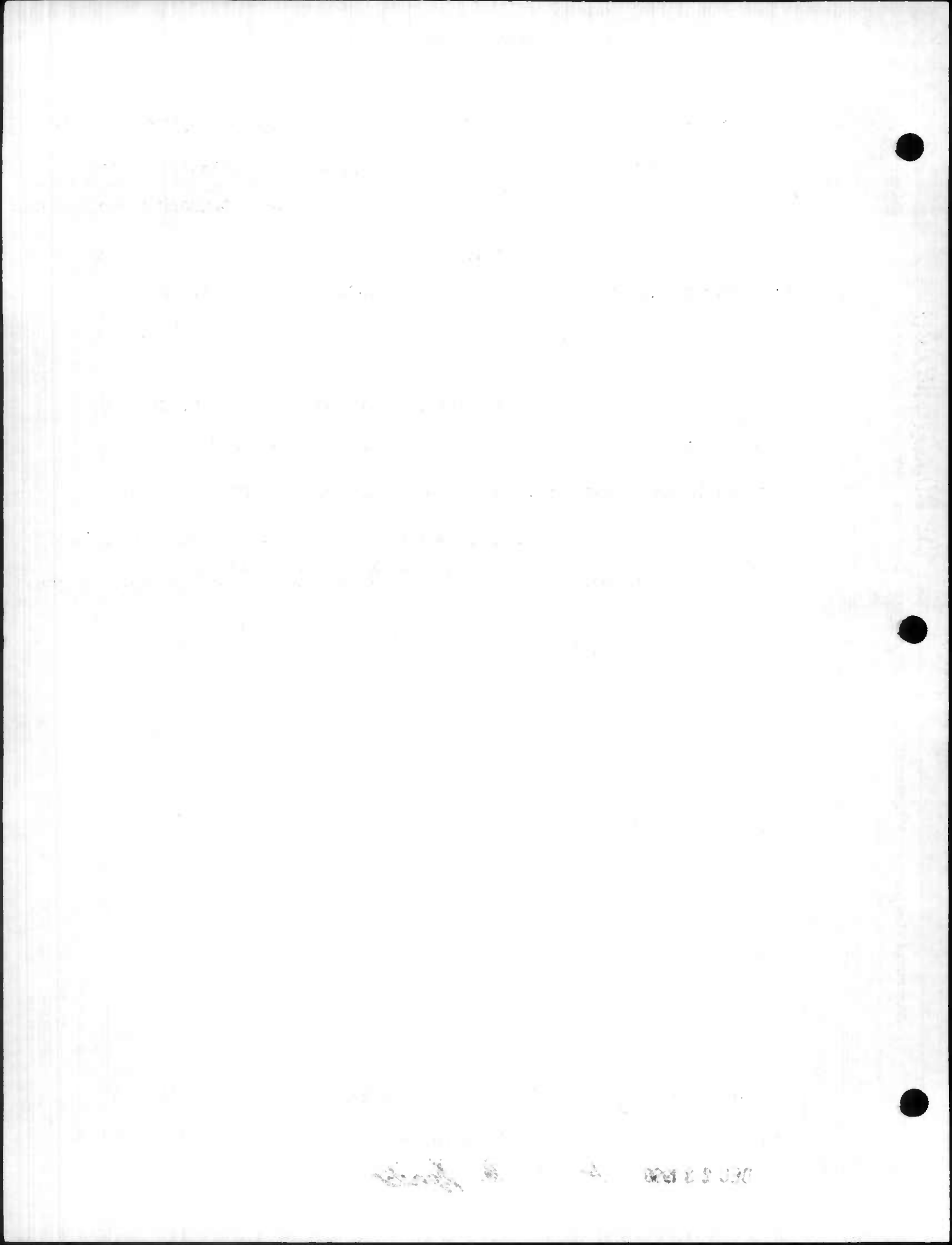
State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41182

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>HASSIE BELL MCDANIEL</b>		2. Date of Death Month <b>December</b> Day <b>19</b> Year <b>1998</b>		3. Time of Death <b>10:35PM</b>
	4e. Facility Name (If not institution, give street and number) <b>Doctor's Hospital</b>		4b. City, Town, or Location of Death <b>Lanham</b>		4c. County of Death <b>Prince Georges</b>
Funeral Director	5. Social Security Number <b>578-84-2852</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>89</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>Nov 30, 1909</b>		9. Birthplace (State or Foreign Country) <b>South Carolina</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent		10a. State <b>MD</b>		10b. County <b>PG</b>
	10c. City, Town or Location <b>Lanham</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <b>5416 Ruxton Drive</b>		10f. Zip Code <b>20706</b>		10g. Citizen of What Country? <b>U.S.A.</b>
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6th</b> College (1-4or 5+)		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Domestic Engineer</b>		16b. Kind of Business/Industry <b>Pvt. Families</b>		
	17. Father's Name (First, Middle, Last) <b>John Dixon</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Frances (Unknown)</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>Mary F. Minor - Daughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5416 Ruxton Drive, Lanham, MD 20706</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Lincoln Memorial Cem.</b>		20c. Location - City or Town, State <b>12/26/98 Suitland, MD</b>
	21. Signature of Funeral Service Licensee <b>J. P. Marshall</b>		22. Name and Address of Facility <b>Marshall's Funeral Home, Inc. 4217 9th Street N.W. Washington DC 20011</b>		
Physician /Medical Examiner	23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Atherosclerotic Cardiovascular Disease</b>				Approximate Interval Between Onset and Death
	Due to (or as a consequence of):				
	Due to (or as a consequence of):				
	Due to (or as a consequence of):				
	Due to (or as a consequence of):				
	Due to (or as a consequence of):				
	Due to (or as a consequence of):				
	Due to (or as a consequence of):				
	Due to (or as a consequence of):				
	Due to (or as a consequence of):				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Cerebrovascular Disease</b>					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <b>George C. Hajjar, Jr.</b>		29c. License number <b>039550</b>		29d. Date signed (Month, Day, Year) <b>12-20-98</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>George C. Hajjar, Jr. M.D. 4850 Forbes Blvd Lanham, Md 20706</b>					
31. Date filed (Month, Day, Year) <b>DEC 23 1998</b>		32. Registrar's Signature <b>[Signature]</b>			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MAXINE E. MILTON

2. Date of Death

Month  
12

Day  
13

Year  
98

3. Time of Death

9:30 am

4a. Facility Name (If not institution, give street and number)

833 English Chestnut Ct.

4b. City, Town, or Location of Death

Landover, Md.

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

577-54-1703

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

59 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
02-01-39

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Prince George's

10c. City, Town or Location

Landover

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

833 English Chestnut Ct.

10f. Zip Code

20785

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married

3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Mail Clerk

16b. Kind of Business/Industry

U.S. Postal Service

17. Father's Name (First, Middle, Last)

Jessie Milton

18. Mother's Name (First, Middle, Maiden Surname)

Elease McDaniel

19a. Informant's Name/Relationship (Type, Print)

Makesia Milton, Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

833 English Chestnut Ct., Landover, Md. 20785

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Harmony Mem. Park

Date

12-17-98

20c. Location - City or Town, State

Landover, Md.

21. Signature of Funeral Service Licensee

*[Signature]*

22. Name and Address of Facility

Ralph Williams Funeral Service

517 11th St., S.E., Wash., DC 20003

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Metastatic Breast Cancer*

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

*4 yrs*

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*[Signature]*

29c. License number

*P18219*

29d. Date signed (Month, Day, Year)

*12/17/98*

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Stephen P. Staal, M.D., 1221 Mercantile Lane, Largo, Md. 20785

State  
Registrar

DEC 21 1998

32. Registrar's Signature

*[Signature]*

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

DEC 31 1983



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41184

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>MARGARET ELIZABETH NIXON</b>				2. Date of Death Month <b>DECEMBER</b> Day <b>27</b> , Year <b>1998</b>		3. Time of Death <b>3:45 PM</b>	
4a. Facility Name (If not institution, give street and number) <b>CUMBERLAND NURSING HOME</b>				4b. City, Town, or Location of Death <b>CUMBERLAND</b>		4c. County of Death <b>ALLEGANY</b>	
5. Social Security Number <b>212-24-1846</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>73</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>FEB. 14, 1925</b>	
9. Birthplace (State or Foreign Country) <b>WEST VIRGINIA</b>		10a. State <b>MD</b>		10b. County <b>ALLEGANY</b>		10c. City, Town or Location <b>CUMBERLAND</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>12414 PINE TREE ROAD, S.E.</b>		10f. Zip Code <b>21502</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+) <b>College</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOMEMAKER</b>		16b. Kind of Business/Industry <b>HOME</b>		17. Father's Name (First, Middle, Last) <b>EDGAR W. SEE</b>	
18. Mother's Name (First, Middle, Maiden Surname) <b>BEATRICE ABE</b>		19a. Informant's Name/Relationship (Type, Print) <b>FRANKLIN J. NIXON / HUSBAND</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>12414 PINE TREE ROAD, SE, CUMBERLAND, MD 21502</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	
20b. Place of Disposition (Name of cemetery, crematory or other place) <b>DAVIS MEMORIAL CEMETERY</b>		20c. Location - City or Town, State <b>CUMBERLAND, MD</b>		20d. Date <b>12/30/98</b>		21. Signature of Funeral Service Licensee <b>Standy N. Upchurch</b>	
22. Name and Address of Facility <b>UPCHURCH FUNERAL HOME, P.A.</b>		22. Name and Address of Facility <b>202 GREENE STREET, CUMBERLAND, MD 21502</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Cardiomyopathy</b> Due to (or as a consequence of):		Approximate Interval Between Onset and Death <b>1 year</b>	
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>COPD</b> <b>AF</b>	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>28b. Time of Injury M</b> <b>28c. Injury at Work? 1 Yes 2 No</b>	
28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Peter Halmos MD</b>	
29c. License number <b>D04981</b>		29d. Date signed (Month, Day, Year) <b>DECEMBER 28, 1998</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>PETER HALMOS, M.D., 302 SCHLEY ST., CUMBERLAND, MD 21502</b>		31. Date filed (Month, Day, Year) <b>DEC 30 1998</b>	
32. Registrar's Signature <b>B. B. B.</b>							

Wm. H. P. & Co.

Per Wm. H. P. & Co.

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41185

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Virginia Mae Orndoff

2. Date of Death

Month Day Year  
Dec. 23, 1998

3. Time of Death

8:00 am

4a. Facility Name (If not institution, give street and number)

678 Fayette Street

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

Funeral  
Director

5. Social Security Number

233-34-7301

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

75

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Mar 17, 1923

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Allegany

10c. City, Town or Location

Cumberland

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

678 Fayette Street

10f. Zip Code

21502

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Cosmetologist

16b. Kind of Business/Industry

Dept. Store

17. Father's Name (First, Middle, Last)

Thomas B. Jones

18. Mother's Name (First, Middle, Maiden Summa)

Anna May (Miller)

19a. Informant's Name/Relationship (Type, Print)

Richard C. Orndoff-son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

16309 Brice Hollow Road SE Cumberland MD 21502

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Rocky Gap Veterans Cem

Date

12/24

20c. Location - City or Town, State

Flintstone MD

21. Signature of Funeral Service Licensee

James F. Scarpelli

22. Name and Address of Facility

Scarpelli Funeral Home, P.A.  
Cumberland MD 21502

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Abdominal Aortic Aneurysm

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

5 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Breast cancer

Chronic obstructive pulmonary disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Sunil Gupta

29c. License number

D33280

29d. Date signed (Month, Day, Year)

Dec 23, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Sunil Gupta; 625 Kent Avenue; Cumberland, MD 21502

31. Date filed (Month, Day, Year)

DEC 23 1998

32. Registrar's Signature

B. Spaw

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

63

State  
Registrar



BRIAN  
PARKER

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41186

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Brian Thaba Parkoe</b>				2. Date of Death Month Day Year <b>DECEMBER 26, 1998</b>		3. Time of Death <b>5:37 P.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>ST. AGNES HOSPITAL</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>202-66-7919</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>16</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>1-21-82</b>	
	9. Birthplace (State or Foreign Country) <b>Germany</b>		10a. State <b>PA</b>		10b. County <b>Delaware</b>		10c. City, Town or Location <b>EAST LANSDOWNE</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>175 HIRST AVE</b>		10f. Zip Code <b>19050</b>		10g. Citizen of What Country? <b>United States</b>	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>Elem.</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Student</b>		16b. Kind of Business/Industry <b>School</b>			
	17. Father's Name (First, Middle, Last) <b>Wesley Parkoe</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Lineo mdckemane</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Wesley Parkoe Father</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>175 HIRST AVE EAST LANSDOWNE PA. 19050</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Fernwood com.</b>		20c. Location - City or Town, State <b>1-2-99 Fernwood PA.</b>		21. Signature of Funeral Service Licensee <b>Keith E. Wharton</b>	
To Be Completed by Physician/Medical Examiner	22. Name and Address of Facility <b>WHARTON FUNERAL HOME</b>				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>a. Head and neck injuries</b> Due to (or as a consequence of):			
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. Manner of Death <input type="checkbox"/> Natural <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			
To Be Completed by Physician/Medical Examiner	28a. Date of Injury (Month, Day, Year) <b>12-26-98</b>				28b. Time of Injury <b>1645 M</b>			
	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28d. Describe how injury occurred <b>Automobile accident</b>			
To Be Completed by Physician/Medical Examiner	28e. Location (Street and Number or Rural Route Number, City or Town, State) <b>Ridge Rd / Greenway</b>				28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>Anne Arundel County, Maryland</b>			
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <b>Stephen S. Radentz, MD</b>			
To Be Completed by Physician/Medical Examiner	29c. License number <b>O.C.M.E.</b>				29d. Date signed (Month, Day, Year) <b>DECEMBER 27, 1998</b>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201</b>				31. Date filed (Month, Day, Year) <b>DEC 31 1998</b>			
To Be Completed by Physician/Medical Examiner	32. Registrar's Signature <b>Brian B. Sparks</b>				33. Date of Death (Month, Day, Year) <b>DEC 26 1998</b>			
	34. Date of Death (Month, Day, Year) <b>DEC 26 1998</b>				35. Date of Death (Month, Day, Year) <b>DEC 26 1998</b>			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41187

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

DARNELL TEPPO PARKER

2. Date of Death

Month Day Year  
Dec 26 1998

3. Time of Death

1800

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

North Arundel Hospital

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

AA

5. Social Security Number

202-66-9934

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. less birthday)

14 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
6-22-84

9. Birthplace (State or Foreign Country)

TACOMA, WASHINGTON

Usual Residence of Decedent

10a. State  
PA

10b. County

Delaware

10c. City, Town or Location

EAST LANSDOWNE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

175 HIRST AVE

10f. Zip Code

19050

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

Elem.

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Student

16b. Kind of Business/Industry

Elem. school

17. Father's Name (First, Middle, Last)

Wesley Parker

18. Mother's Name (First, Middle, Maiden Surname)

Lineo Mokemane

19a. Informant's Name/Relationship (Type, Print)

Wesley Parker

Father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

875 HIRST AVE EAST LANSDOWNE, PA. 19050

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Ferwood Cem.

Date

1-2-99

20c. Location - City or Town, State

Ferwood PA

21. Signature of Funeral Service Licensee

Keith E. Wharton

22. Name and Address of Facility

WHARTON FUNERAL HOME  
22171 Wharton Rd Accomac, VA 23301

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Multiple Trauma

Approximate Interval Between Onset and Death  
INSTANT

Due to (or as a consequence of):

b. Motor Vehicle Accident

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient

2 ☒ Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

12-26-98

28b. Time of Injury

1645M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Vehicle Collision

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Street

28f. Location (Street and Number or Rural Route Number, City or Town, State)

HANOVER, MD

29a. Certifier (Check only one)

1 ☐ Certifying Physician

2 ☒ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

William P. Jones, MD Deputy

29c. License number

D 06054

29d. Date signed (Month, Day, Year)

12-26-98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William P. Jones, MD 695 America 21035

31. Date filed (Month, Day, Year)

DEC 31 1998

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

10



1. The first part of the report is a summary of the work done during the year.

2. The second part is a detailed account of the experiments carried out.

3. The third part is a discussion of the results obtained.

4. The fourth part is a conclusion drawn from the work.

5. The fifth part is a list of references.

6. The sixth part is a list of symbols and abbreviations.

7. The seventh part is a list of figures.

8. The eighth part is a list of tables.

9. The ninth part is a list of appendices.

10. The tenth part is a list of footnotes.

11. The eleventh part is a list of errata.

12. The twelfth part is a list of acknowledgments.

13. The thirteenth part is a list of references.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41188

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mary Eloise Parnell				2. Date of Death Month Day Year 12 24 1998		3. Time of Death 19:15PM	
	4a. Facility Name (If not institution, give street and number) St. Mary's Hospital				4b. City, Town, or Location of Death Leonardtown		4c. County of Death St. Mary's	
Funeral Director	5. Social Security Number 262-01-6855	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (in yrs. last birthday) 83 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) September 7, 1915		9. Birthplace (State or Foreign Country) Florida
	Usual Residence of Decedent							
10a. State Maryland		10b. County St. Mary's		10c. City, Town or Location Dameron			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 49520 Lois Lane				10f. Zip Code 20638		10g. Citizen of What Country? U.S.A.		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Site Foreman			16b. Kind of Business/Industry Metal Shop	
17. Father's Name (First, Middle, Last) Dawson Wilkinson				18. Mother's Name (First, Middle, Maiden Surname) Laura Glisson				
19a. Informant's Name/Relationship (Type, Print) Margo Parnell/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 49520 Lois Lane, Dameron, MD 20638				
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		Date 12/29/98		20c. Location - City or Town, State Alexandria, VA
21. Signature of Funeral Service Licensee Michael K. Gardiner				22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, MD 20650				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Chronic Lung Disease Due to (or as a consequence of): b. Cancer of the Lung Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death YRS YRS
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier William Boyd II				29c. License number 014285		29d. Date signed (Month, Day, Year) 12/26/98		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William Boyd II, MD Leonardtown, MD 20650								
31. Date filed (Month, Day, Year) DEC 29 1998		32. Registrar's Signature B. Sparks						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Parnell, Mary E



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41189

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) <b>Clarence William Painter, Sr.</b>				2. Date of Death Month <b>December</b> Day <b>28</b> , Year <b>1998</b>		3. Time of Death <b>10:45 AM</b>	
4a. Facility Name (If not institution, give street and number) <b>MEMORIAL HOSPITAL</b>				4b. City, Town, or Location of Death <b>CUMBERLAND</b>		4c. County of Death <b>ALLEGANY</b>	
5. Social Security Number <b>214-05-5432</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>86</b> Yrs.		8. Date of Birth <b>February 4, 1912</b>	
9. Birthplace (State or Foreign Country) <b>Maryland</b>							
Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Alleghany</b>		10c. City, Town or Location <b>Cumberland</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10a. Street and Number <b>115 Columbia Street</b>				10f. Zip Code <b>21502</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WW II</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>XX</b>		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Electrician</b>		16b. Kind of Business/Industry <b>B&amp;O Railroad</b>	
17. Father's Name (First, Middle, Last) <b>William Ashby Painter</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>G. Nellie Rowe</b>			
19a. Informant's Name/Relationship (Type, Print) <b>James E. Painter, I Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>720 Frederick St. Cumberland, Maryland 21502</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Sunset Memorial Park</b>		Data <b>12-31-98</b>		20c. Location - City or Town, State <b>Cumberland, MD</b>	
21. Signature of Funeral Service Licensee <b>Robert E. Evans</b>				22. Name and Address of Facility <b>Leasure-Stein Funeral Home 230 Baltimore Avenue Cumberland MD 21502</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>CHRONIC RENAL FAILURE</b> Due to (or as a consequence of):  b. <b>NEPHROSCLEROSIS</b> Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.  Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
Approximate Interval Between Onset and Death <b>24 MONTHS</b> <b>24 MONTHS</b>							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
						24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how Injury occurred			
		28t. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier <b>Robustiano Barrera</b>				29c. License number <b>D14865</b>		29d. Date signed (Month, Day, Year) <b>December 28 1998</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>ROBUSTIANO BARRERA, M.D., MEMORIAL MEDICAL BUILDING CUMBERLAND MD 21502</b>							
31. Date filed (Month, Day, Year) <b>DEC 30 1998</b>				32. Registrar's Signature <b>[Signature]</b>			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

CLARENCE PAINTER 214-05-5432

Division of Vital Records, P.O. Box 68760,

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41190

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Gilbert L. Plummer</b>				2. Date of Death Month Day Year <b>DECEMBER 18, 1998</b>				3. Time of Death <b>1:25 P.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>Sacred Heart Hospital</b>				4b. City, Town, or Location of Death <b>Cumberland</b>				4c. County of Death <b>Allegany</b>	
Funeral Director	5. Social Security Number <b>214-12-3137</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>79</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>26-Oct-19</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent				10a. State <b>Maryland</b>		10b. County <b>Allegany</b>		10c. City, Town or Location <b>Frostburg</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number <b>210 West Mechanic Street</b>				10f. Zip Code <b>21532</b>	
	10g. Citizen of What Country? <b>U.S.A.</b>				11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WWII</b>	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>0</b>	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Painter</b>				16b. Kind of Business/Industry <b>Defense Contractor</b>				17. Father's Name (First, Middle, Last) <b>Robert Plummer</b>	
To Be Completed by Physician/Medical Examiner	18. Mother's Name (First, Middle, Maiden Surname) <b>Hazel Streets</b>				19a. Informant's Name/Relationship (Type, Print) <b>Blanche Plummer Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Apt. 324 Frostburg Maryland 21532</b>	
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Cumberland Crematory</b>				20c. Location - City or Town, State <b>19-Dec-98 Cumberland, Maryland</b>	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532</b>				23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>RESPIRATORY FAILURE, ACUTE</b> Due to (or as a consequence of): <b>ACUTE BILATERAL PNEUMONIA</b> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined	
	28a. Date of Injury (Month, Day, Year)				28b. Time of Injury M				28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier 				29c. License number <b>D24951</b>	
To Be Completed by Physician/Medical Examiner	29d. Date signed (Month, Day, Year) <b>December, 18, 1998</b>				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Chang H. Oh, M.D., 48 Tam Terrace, Frostburg, Maryland 21532</b>				31. Date filed (Month, Day, Year) <b>DEC 21 1998</b>	
	32. Registrar's Signature 				33. State Registrar <b>DEC 21 1998</b>				34. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	

Dust Funeral Home, 52 First Ave., Frostburg, MD 21532

Cumberland Cemetery 19-Dec-98 Cumberland, Maryland

Blanche Plummer Wife Apt. 324 Frostburg Maryland 21532-

Robert Plummer

Hazel Streetz

11 0 Painter Defense Contractor

Wife

21532-

U.S.A.

210 West Mechnic Street

Maryland Allegany Frostburg

214-12-3132

79

28-Oct-19

Maryland

Cumberland

Allegany

Sacred Heart Hospital

Gilbert L. Plummer



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41191

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Lloyd Wesley Payne</b>				2. Date of Death Month <b>December</b> Day <b>21</b> Year <b>1998</b>		3. Time of Death <b>8:05AM</b>	
4a. Facility Name (If not institution, give street and number) <b>4009 Suit Road</b>				4b. City, Town, or Location of Death <b>Forestville</b>		4c. County of Death <b>Prince George's</b>	
5. Social Security Number <b>578-26-8864</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>73</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>June 18, 1925</b>	
9. Birthplace (State or Foreign Country) <b>Maryland</b>							
Usual Residence of Decedent				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10a. State <b>Maryland</b>		10b. County <b>Prince George's</b>		10c. City, Town or Location <b>Forestville</b>			
10e. Street and Number <b>4009 Suit Road</b>				10f. Zip Code <b>20747</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>1943-1946</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10th</b> College (1-4or 5+) <b>N/A</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Truck Driver</b>		16b. Kind of Business/Industry <b>Amoco Gas</b>	
17. Father's Name (First, Middle, Last) <b>James Lloyd Payne</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Etta Grieson</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Frances P. Payne (Wife)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4009 Suit Road Forestville, Maryland 20747</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Cedar Hill Cemetery</b>		Data <b>Dec. 24, 1998</b>		20c. Location - City or Town, State <b>Suitland, Maryland</b>	
21. Signature of Funeral Service Licen 				22. Name and Address of Facility <b>Lee Funeral Home, Inc. 6633 Old Alexander Ferry Rd. Clinton, Md. 20735</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>CORONARY ARTERY DISEASE 71 YR</b> <b>HYPERLIPIDEMIA 71 YR</b> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>DIABETES MELLITUS</b>							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DIABETES MELLITUS</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred			
		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier 				29c. License number <b>D27744</b>		29d. Date signed (Month, Day, Year) <b>12-22-98</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>RAJ. SAMTANI MD 9131 Piscataway Rd #280 Clinton, Md 20735</b>							
31. Date filed (Month, Day, Year) <b>DEC 22 1998</b>				32. Registrar's Signature 			

15

State  
Registrar



**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

Reg. No. **98-41102**

**Physician  
/Medical  
Examiner**

**Funeral  
Director**

1. Decedent's Name (First, Middle, Last) <b>Logan M. Phillips</b>				2. Date of Death Month <b>Dec.</b> Day <b>18,</b> Year <b>1998</b>		3. Time of Death <b>4:30a.m.</b>			
4a. Facility Name (If not institution, give street and number) <b>3902 23RD PARKWAY</b>				4b. City, Town, or Location of Death <b>TEMPLE HILLS</b>		4c. County of Death <b>PG</b>			
5. Social Security Number <b>243-12-4998</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>81</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>9/17/17</b>			
9. Birthplace (State or Foreign Country) <b>GAFFNEY, SC</b>									
Usual Residence of Decedent									
10a. State <b>MD</b>		10b. County <b>PG</b>		10c. City, Town or Location <b>TEMPLE HILLS</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10e. Street and Number <b>3902 23RD PARKWAY</b>				10f. Zip Code <b>20748</b>		10g. Citizen of What Country? <b>USA</b>			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Years <b>46</b> <b>ARMY</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+) <b>NONE</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOUSEKEEPER</b>		16b. Kind of Business/Industry <b>CIA FEDERAL GOVERNMENT</b>			
17. Father's Name (First, Middle, Last) <b>HENRY PHILLIPS</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>MINNIE (UNK)</b>					
19a. Informant's Name/Relationship (Type, Print) <b>ALLIE HOLMES PHILLIPS (WIFE)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>SAME AS 10A,B,C,D,E,&amp;F</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MD VETERAN CEMETERY</b>		Date <b>12/24/98</b>		20c. Location - City or Town, State <b>CHELTENHAM, MD</b>			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>JOHN T. RHINES CO., INC. 3030 12TH ST NE, DC 20017</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p><b>CARDIO PULMONARY ARREST</b></p> <p>Due to (or as a consequence of):</p> <p><b>METASTATIC PROSTATE CANCER</b></p> </div> <div style="width: 30%;"> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> </div> </div>								Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)		28b. Time of injury <b>M</b>		28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No			
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred					
28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier 				29c. License number <b>9584</b>		29d. Date signed (Month, Day, Year) <b>12/21/98</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>BARRY SMITH, MD 1328 SOUTHERN AVENUE SE, DC 20032, #213</b>									
31. Date filed (Month, Day, Year) <b>DEC 21 1998</b>				32. Registrar's Signature 					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

**7**

11

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41193

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ROOSEVELT ROBINSON</b>				2. Date of Death Month <b>DECEMBER</b> Day <b>23</b> Year <b>1998</b>		3. Time of Death <b>1:20 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>6145 QUANTICO RD</b>				4b. City, Town, or Location of Death <b>QUANTICO</b>		4c. County of Death <b>WICOMICO</b>		
Funeral Director	5. Social Security Number <b>280-26-1788</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (in yrs. last birthday) <b>66</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>AUGUST 18 1932</b>	9. Birthplace (State or Foreign Country) <b>MD</b>	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State <b>MD</b>		10b. County <b>WICOMICO</b>		10c. City, Town or Location <b>QUANTICO</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number <b>6145 QUANTICO</b>				10f. Zip Code <b>21856</b>		10g. Citizen of What Country? <b>US</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11 YEARS</b>		College (1-4 or 5+)		18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>FARMER</b>		16b. Kind of Business/Industry <b>AGRICULTURE</b>		
	17. Father's Name (First, Middle, Last) <b>LEVIN W. ROBINSON</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>LOLA PRICE</b>				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>EDNA ROBINSON WIFE</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6145 QUANTICO RD QUANTICO, MD 21856</b>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>HD OF CK CEMETERY</b>		20c. Location - City or Town, State <b>QUANTICO, MD</b>		20d. Date <b>12/25/98</b>		
	21. Signature of Funeral Service Licensee <b>C. J. [Signature] MOOCH</b>				22. Name and Address of Facility <b>MESSICK FUNERAL HOME PO BOX 61 BIVILLE, MD. 21814</b>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Metastatic Cancer</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							Approximate Interval Between Onset and Death <b>6 months</b>	
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier <b>[Signature] MD</b>				29c. License number <b>026278</b>		29d. Date signed (Month, Day, Year) <b>12-26-98</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>David Connell, MD 145 E. Connell St. Solihy, MD 21801</b>									
31. Date filed (Month, Day, Year) <b>DEC 28 1998</b>				32. Registrar's Signature <b>[Signature]</b>					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41194

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

EDWARDINA A. RIGGS

2. Date of Death

Month Day Year

Dec. 20 1998

3. Time of Death

1015pm

4a. Facility Name (If not institution, give street and number)

Howard County General Hospital

4b. City, Town, or Location of Death

Columbia, MD

4c. County of Death

Howard

5. Social Security Number

217-84-2345

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

35

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

6. Date of Birth

(Month, Day, Year)

July 18, 1963

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Howard

10c. City, Town or Location

Ellicott City

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4911 Webbed Foot Way

10f. Zip Code

21043

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Title Clerk

16b. Kind of Business/Industry

Automotive

17. Father's Name (First, Middle, Last)

Joseph Luther

16. Mother's Name (First, Middle, Maiden Surname)

Charlotte E. Williams

19a. Informant's Name/Relationship (Type, Print)

Charlotte Williams Riggs (mother)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4911 Webbed Foot Way, Ellicott City, MD 21043

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Carroll Cremation Serv.

Date

12/24/98 Hampstead, MD

21. Signature of Funeral Service Licensee

Briane S. Haight

22. Name and Address of Facility

HAIGHT FUNERAL HOME &amp; CHAPEL, PA (Box 195)

Sykesville, MD 21784 (410)-795-1400

23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

(Staphylococcus)

Immediate Cause (Final disease or condition resulting in death)

a. Meticillin Resistant Staph. Aureus Sepsis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus

Multiple Sclerosis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

N. Sauvey MD

29c. License number

D42465

29d. Date signed (Month, Day, Year)

Dec. 21, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Knoll North Dr. Columbia MD 21045 - N. SAUVEY M.D.

31. Date filed (Month, Day, Year)

DEC 22 1998

32. Registrar's Signature

Berna B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41195

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Anita Elizabeth Raley

2. Date of Death

Month Day Year  
December 26 1998

3. Time of Death

9:37 PM

4a. Facility Name (If not institution, give street and number)

St. Mary's Hospital

4b. City, Town, or Location of Death

Leonardtown

4c. County of Death

St. Mary's

Funeral  
Director

5. Social Security Number

220-16-8739

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

72

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
February 21, 1926

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

St. Mary's

10c. City, Town or Location

Dameron

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

18300 St. Jeromes Neck Road

10f. Zip Code

20628

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

To Be Completed by Funeral Director

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

Collage (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working

life. DO NOT use retired)

Clerk

16b. Kind of Business/Industry

United States  
Postal Service

17. Father's Name (First, Middle, Last)

Francis Chester Cullison

18. Mother's Name (First, Middle, Maiden Surname)

Anna Marie Peacock

19a. Informant's Name/Relationship (Type, Print)

Robert W. Raley, Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

18300 St. Jeromes Neck Road, Dameron, MD 20628

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

St. Michael's Cemetery

Date

12-29-98

20c. Location - City or Town, State

Ridge, Maryland

21. Signature of Funeral Service Licensee

Edward N. Brinsfield, Jr. M00052

22. Name and Address of Facility

Brinsfield Funeral Home, P.A.

22955 Hollywood Road, Leonardtown, MD 20650

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Cardiopulmonary failure*  
Due to (or as a consequence of):b. *Septic Shock*  
Due to (or as a consequence of):c.   
Due to (or as a consequence of):d.   
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

1 day  
2 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I

*Lymphoma, gastric*

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicida 4 ☐ Homicida

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)2 ☒ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Philip J. Bean

29c. License number

D06419

29d. Date signed (Month, Day, Year)

12-28-98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JAMES P. JARBOE M.D. PHILIP J. BEAN MEDICAL CENTER HOLLYWOOD, MD. 20636

31. Date filed (Month, Day, Year)

DEC 29 1998

32. Registrar's Signature

Benita S. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

ANITA ELIZABETH RALEY  
Division of Vital Records, P.O. Box 68760,To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41196

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Francis Edwin Rinker

2. Date of Death

Month Day Year  
Dec. 25, 1998

3. Time of Death

1:45 P.M.

4a. Facility Name (If not institution, give street and number)

Devlin Manor Nursing Home

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Alleghany

Funeral  
Director

5. Social Security Number

214-07-4489

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
July 6, 1911

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland Alleghany

10b. County

10c. City, Town or Location

Cumberland

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

220 Somerville Ave. A-213

10f. Zip Code

21502

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☒ Yes ☐ No 7/26/44  
If Yes, Give  
Year or Dates: 12/1/45

13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

Collega (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Construction Worker

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

James R. Rinker

18. Mother's Name (First, Middle, Maiden Surname)

Effie O'Neal

19a. Informant's Name/Relationship (Type, Print)

Genevieve Rinker/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

220 Somerville Ave A-213 Cumberland, Md. 21502

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Rocky Gap Vet. Cemetery

Date

12/30/98

20c. Location - City or Town, State

Cumberland, Md/

21. Signature of Funeral Service Licensee

Eust A. Rinker

22. Name and Address of Facility

Leasure-Stein Funeral Home 230 Baltimore  
Cumberland, Md. 21502

23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.

Immediate Cause (Final  
disease or condition  
resulting in death)

a. chronic obstructive pulmonary disease

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

10 years

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown

24a. Was an autopsy  
performed?

☐ Yes ☒ No

24b. Were autopsy findings  
available prior to  
completion of cause  
of death?

☐ Yes ☐ No

25. Was case referred to medical  
examiner?

☐ Yes ☒ No

Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other: ☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury  
(Month, Day, Year)

28b. Time of  
Injury

28c. Injury at  
Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)

29a. Certifier  
(Check only  
one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Sunil Gupta

29c. License number

D33280

29d. Date signed (Month, Day, Year)

Dec 28, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SUNIL GUPTA MD, 625 KENT AVE

CUMBERLAND MD 21502

31. Date filed (Month, Day, Year)

DEC 28 1998

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

4

State  
Registrar



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41197

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

DOROTHY LEE RITCHIE

2. Date of Death

Month Day Year  
DECEMBER 26 1998

3. Time of Death

01:10 AM

4a. Facility Name (If not institution, give street and number)

MEMORIAL HOSPITAL

4b. City, Town, or Location of Death

CUMBERLAND

4c. County of Death

ALLEGANY

Funeral  
Director

5. Social Security Number

213-24-7142

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

70

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
MAY 6 1928

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ALLEGANY

10c. City, Town or Location

CUMBERLAND

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

14908 UHL HIGHWAY S.E.

10f. Zip Code

21502

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

TOWN &amp; COUNTRY/SHEETZ/M.V.A.

16b. Kind of Business/Industry

CLERK

17. Father's Name (First, Middle, Last)

OTIS EVERETT

18. Mother's Name (First, Middle, Maiden Surname)

GEORGIA ZIMMERLY

19a. Informant's Name/Relationship (Type, Print)

BRENDA L. GLAZE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

DAUGHTER 14908 UHL HIGHWAY S.E. CUMBERLAND MARYLAND 21502

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Date

20c. Location - City or Town, State

DAVIS MEMORIAL CEMETERY DEC 29 1998 CUMBERLAND MARYLAND

21. Signature of Funeral Service Licensee

Dale L. Merritt

22. Name and Address of Facility

MERRITT-ADAMS FUNERAL HOME

404 DECATUR STREET CUMBERLAND MARYLAND

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

e. Coronary Artery Disease

20 years

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

{

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No

25. Was case referred to medical

examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient3 ☒ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)

29a. Certifier

(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

DR GUY FISCUS MEMORIAL HOSPITAL MEDICAL BUILDING CUMBERLAND MARYLAND 21502

State  
Registrar

31. Date (Month, Day, Year)

DEC 28 1998

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filled within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 41198

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>James Paul Rogers I</b>				2. Date of Death Month Day Year <b>December 17, 1998</b>				3. Time of Death <b>0230 a.m.</b>													
	4a. Facility Name (If not institution, give street and number) <b>Sacred Heart Hospital</b>				4b. City, Town, or Location of Death <b>Cumberland</b>				4c. County of Death <b>Allegany</b>													
Funeral Director	5. Social Security Number <b>254-03-3711</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>86</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Mar 10, 1912</b>		9. Birthplace (State or Foreign Country) <b>NC</b>													
	Usual Residence of Decedent																					
To Be Completed by Funeral Director	10a. State <b>MD</b>		10b. County <b>Allegany</b>		10c. City, Town or Location <b>LaVale</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No													
	10e. Street and Number <b>5 Roger Way</b>				10f. Zip Code <b>21502</b>		10g. Citizen of What Country? <b>USA</b>															
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>white</b>														
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Certified Public Accountant</b>				16b. Kind of Business/Industry <b>Accounting</b>													
	17. Father's Name (First, Middle, Last) <b>James David Rogers</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Lola (Bradley)</b>																	
	19a. Informant's Name/Relationship (Type, Print) <b>Ruth E. Rogers-wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5 Roger Way LaVale MD 21502</b>																	
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>SS Peter Paul Cemetery</b>		Date <b>12/19</b>		20c. Location - City or Town, State <b>Cumberland MD</b>															
	21. Signature of Funeral Service Licensee <i>Nicholas J. Scarpelli</i>				22. Name and Address of Facility <b>Scarpelli Funeral Home, P.A. Cumberland MD 21502</b>																	
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																					
	<table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a.</td> <td><b>RESPIRATORY FAILURE</b></td> <td><b>12 DAYS</b></td> </tr> <tr> <td>b.</td> <td><b>BILATERAL PNEUMONIA</b></td> <td><b>17 DAYS</b></td> </tr> <tr> <td>c.</td> <td></td> <td></td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	<b>RESPIRATORY FAILURE</b>	<b>12 DAYS</b>	b.	<b>BILATERAL PNEUMONIA</b>	<b>17 DAYS</b>	c.			d.	
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	<b>RESPIRATORY FAILURE</b>	<b>12 DAYS</b>																			
	b.	<b>BILATERAL PNEUMONIA</b>	<b>17 DAYS</b>																			
	c.																					
	d.																					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b> <b>CORONARY ARTERY DISEASE</b>																						
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown																						
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																						
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																						
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined																						
28a. Date of Injury (Month, Day, Year)																						
28b. Time of Injury <b>M</b>																						
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																						
28d. Describe how injury occurred																						
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)																						
28f. Location (Street and Number or Rural Route Number, City or Town, State)																						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																						
29b. Signature and title of certifier <i>Chang Oh M.D.</i>																						
29c. License number <b>D24951</b>																						
29d. Date signed (Month, Day, Year) <b>December 17, 1998</b>																						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Chang Oh M.D. 48 Tarn Terrace Frostburg MD 21532</b>																						
31. Date filed (Month, Day, Year) <b>DEC 21 1998</b>																						
32. Registrar's Signature <i>[Signature]</i>																						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41199

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

SUSIE W. RAGINS

2. Date of Death  
Month Day Year

December 12, 1998

3. Time of Death

7:25pm

4a. Facility Name (If not institution, give street and number)

HILLHAVEN NURSING HOME

4b. City, Town, or Location of Death

ADELPHI

4c. County of Death

PRINCE GEORGES

Funeral  
Director

5. Social Security Number

579-09-1733

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

83

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

Sept. 17, 1915 South Carolina

9. Birthplace (State or Foreign Country)

Usual Residence of Decedent

10a. State

10b. County

10c. City, Town or Location

Washington, D.C.

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5108 KANSAS AVE. N.W.

10f. Zip Code

20011

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12th

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

CLERK

16b. Kind of Business/Industry

FEDERAL GOVERNMENT

17. Father's Name (First, Middle, Last)

EDWARD WATSON

18. Mother's Name (First, Middle, Maiden Surname)

MILLIE FLUDD

19a. Informant's Name/Relationship (Type, Print)

BETTY HARDERMAN/DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4341 GREENBERRY LANE, ANNANDALE VA. 22003

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

FORT LINCOLN CEMETERY 12/19/98

Data

20c. Location - City or Town, State

BRENTWOOD, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

JOHNSON &amp; JENKINS INC.

716 KENNEDY ST., N.W. WASH. D.C. 20011

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Cerebrovascular accident*  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 1/2 yr

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*Diabetes*

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ NO 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ NO

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ NO

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined28a. Date of Injury  
(Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

036716

29d. Date signed (Month, Day, Year)

December 16, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Andrew Kundrat M.D. 8310 Cherry Lane Laurel, Md. 20707

31. Date filed (Month, Day, Year)

DEC 21 1998

32. Registrar's Signature

*[Signature]*State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41200

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Bladen

Russell

2. Date of Death

December 17, 1998

3. Time of Death

04 A.M.

4a. Facility Name (If not institution, give street and number)

2015 East West Highway

FOX CHASE

NURSING HOME

4b. City, Town, or Location of Death

Silver Spring, MD

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

224-16-6325

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

82

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

Dec 9, 1916

9. Birthplace (State or Foreign Country)

Warrenton, VA

Usual Residence of Decedent

10a. State

10b. County

10c. City, Town or Location

Washington, DC

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

5012 4th Street NW

10f. Zip Code

20011

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.  
Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Engineer

16b. Kind of Business/Industry

D.C. Public Schools

17. Father's Name (First, Middle, Last)

Bladen Russell, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Jennie Clay Russell

19a. Informant's Name/Relationship (Type, Print)

Dolores C. Russell / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5012 4th Street NW, Washington, DC 20011

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Quantico National Cemetery

Date

12/23/98

20c. Location - City or Town, State

Triangle, VA

21. Signature of Funeral Service Licensee

Pope Funeral Home

22. Name and Address of Facility

Pope Funeral Home

5538 Marlboro Pike / Forestville, MD 20747

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Carcinoma of lung  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive heart failure Diabetes mellitus

Anemia, Chronic renal insufficiency

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Muhammad Ejaz M.D.

29c. License number

D0052255

29d. Date signed (Month, Day, Year)

Dec. 17, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Muhammad Ejaz 8609 2nd Ave #404B Silver Spring, M.D. 20910

31. Date filed (Month, Day, Year)

DEC 21 1998

32. Registrar's Signature

[Signature]

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

12

State  
Registrar

DEC 5 1980



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41201

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

LEE HAROLD SMITH JR.

2. Date of Death

Month December 27, 1998

3. Time of Death

11:09 AM

4a. Facility Name (If not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

5. Social Security Number

219-51-2756

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

March 16, 1998

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Maugansville

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

13802 Sunrise Drive

10f. Zip Code

21767

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☒ Never Married ☐ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces?

☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☒ Yes ☐ No Specify: Mexican

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

Collage (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

Lee Harold Smith Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Laura Ann Boyd

19a. Informant's Name/Relationship (Type, Print)

Laura Ann Smith

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13802 Sunrise Drive, Maugansville, Md. 21767

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Rose Hill Cemetery 12-30-98

Date

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee

R. Noel Brady

22. Name and Address of Facility

Andrew K. Corlman Funeral Home, Inc.  
40 East Antietam Street, Hagerstown, Md. 21740

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. MENINGOCOCCAL SEPTICEMIA

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

HOURS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☒ Yes ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient

☒ Outpatient

☐ DOA

Other:

☐ Nursing Home

☐ Residence

☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Suicide  
☐ Homicide ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J. N. N. MD.

29c. License number

D51541

29d. Date signed (Month, Day, Year)

12 27 98

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

JAI NAHAR, MD THE CHILDREN'S DOCTOR 319 EAST ANTIENTAM STREET.

31. Date filed (Month, Day, Year)

DEC 29 1998

32. Registrar's Signature

B. Sparks

HAGERSTOWN, MD 21740

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Smith, Lee Harold Jr.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 41202

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Pauline S. SHANK

2. Date of Death

Month Day Year  
Dec. 26, 1998

3. Time of Death

5:00 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Twin Oaks Retirement Center

4b. City, Town, or Location of Death

Williamsport

4c. County of Death

WASHINGTON

5. Social Security Number

212-24-3753

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

72 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Feb. 22, 1926

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

Washington

10c. City, Town or Location

Williamsport

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

16137 Cloverton Lane

10f. Zip Code

21795

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12College (1-4 or 5+)  
016a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Administrative Assistant

16b. Kind of Business/Industry

Utility

17. Father's Name (First, Middle, Last)

Cecil

Shaw

18. Mother's Name (First, Middle, Maiden Surname)

Annie

Kuykendall

19a. Informant's Name/Relationship (Type, Print)

Lee D. Shank (husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

16137 Cloverton Lane Williamsport, MD 21795  
Greenlawn Memorial Park Dec. 29, 1998 Williamsport, MD 21795

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

OSBORNE FUNERAL HOME

P.O. Box # 348 Williamsport, MD 21795

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)e. Ovarian Cancer  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death

2 1/2 years

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

hypertension

hypothyroidism

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Assisted living

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
2 ☐ Accident investigation  
3 ☐ Suicide 6 ☐ Could not be  
4 ☐ Homicide determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Cynthia Kuttner-Sands, MD

29c. License number

D47451

29d. Date signed (Month, Day, Year)

12/28/98

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Dr. Cynthia Kuttner-Sands, MD 11110 Medical Campus Rd. Hagerstown, MD 21742

31. Date filed (Month, Day, Year)

DEC 28 1998

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



98 41203

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Jean M Statton</i>				2. DATE OF DEATH MONTH DAY YEAR <i>December 24 1998</i>		3. TIME OF DEATH <i>1345</i> M	
4. SOCIAL SECURITY NUMBER <i>354-16-3814</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>75</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>August 13, 1923</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>University of Maryland</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i>		9c. COUNTY OF DEATH <i>Baltimore</i>	
10a. STATE <i>Maryland</i>				10b. COUNTY <i>Washington</i>		10c. CITY, TOWN OR LOCATION <i>Hagerstown</i>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <i>13211 Woodbine Lane</i>			
10f. ZIP CODE <i>21742</i>				10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>white</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>0-12</i> College (1-4 or 5+) <i>4</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>house wife</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Own home</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Bert C. McCulloch</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Majorie Verbeck</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Mr. Philip J. Statton/son</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1022 Lindsay Lane, Hagerstown, Maryland 21742</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Rose Hill Cemetery</i>		20c. LOCATION — City or Town, State <i>Dec 28, 1998 Hagerstown, Maryland</i>		20d. LOCATION — City or Town, State <i>21740</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Scott H. Minich</i>				22. NAME AND ADDRESS OF FACILITY <i>Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Pneumothorax</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>sepsis</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i>myocardial infarction</i> DUE TO (OR AS A CONSEQUENCE OF): d. <i>emphysema</i> Approximate Interval Between Onset and Death							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Adam Clark M.D.</i>				29c. LICENSE NUMBER <i>P11743</i>		29d. DATE SIGNED (Month, Day, Year) <i>December 24, 1998</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Adam Clark 22 S. Greene</i>							
31. DATE FILED (Month, Day, Year) <i>DEC 28 1998</i>				32. REGISTRAR'S SIGNATURE <i>P. Sparks</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 41204

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Martin Samuel Shuck</b>				2. Date of Death Month <b>December</b> Day <b>24</b> Year <b>1998</b>		3. Time of Death <b>0500</b>	
	4a. Facility Name (If not institution, give street and number) <b>14710 BYERS ROAD</b>				4b. City, Town, or Location of Death <b>HAGERSTOWN</b>		4c. County of Death <b>WASHINGTON</b>	
Funeral Director	5. Social Security Number <b>214-34-0829</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (in yrs. last birthday) <b>80</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>APR 8 1918</b>	9. Birthplace (State or Foreign Country) <b>HAGERSTOWN, MD</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>MD</b>	10b. County <b>WASHINGTON</b>	10c. City, Town or Location <b>HAGERSTOWN</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>14710 BYERS ROAD</b>				10f. Zip Code <b>21742</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>FARMER</b>		16b. Kind of Business/Industry <b>OWN FARM.</b>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>HARRY M SCHUCK</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>CLARA SUSAN MARTIN</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>TERRY L SCHUCK / SON</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>14616 BYERS RD HAGERSTOWN MD 21742</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>REST HAVEN CEMETERY</b>		Date <b>12/30</b>		20c. Location - City or Town, State <b>HAGERSTOWN, MD</b>	
	21. Signature of Funeral Service Licensee <b>John C Lynch</b>				22. Name and Address of Facility <b>MILLER-GROVE FUNERAL HOME 521 SWASHINGTON ST GREENCASTLE PA</b>			
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Arteriosclerotic cardiovascular disease years</b>							Approximate Interval Between Onset and Death
	Due to (or as a consequence of):							
	Due to (or as a consequence of):							
	Due to (or as a consequence of):							
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. <b>Hypertension</b> <b>Rheumatoid arthritis</b>								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>[Signature]</b>		29c. License number <b>D26806</b>		29d. Date signed (Month, Day, Year) <b>12/24/98</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Atlanta Bus 747 Norton Ave Hagerstown MD 21742</b>								
31. Date filed (Month, Day, Year) <b>DEC 28 1998</b>		32. Registrar's Signature <b>[Signature]</b>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar






Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41205

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Helen M. Still</b>				2. Date of Death Month <b>Dec.</b> Day <b>23</b> Year <b>1998</b>		3. Time of Death <b>8:30Am</b>	
	4a. Facility Name (If not institution, give street and number) <b>Salisbury Center; Genesis ElderCare</b>				4b. City, Town, or Location of Death <b>Salisbury, Md.</b>		4c. County of Death <b>Wicomico</b>	
Funeral Director	5. Social Security Number <b>428-10-1619</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>89</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>7/27/1909</b>	
	9. Birthplace (State or Foreign Country) <b>Mississippi</b>		10a. State <b>MD</b>		10b. County <b>Wicomico</b>		10c. City, Town or Location <b>Salisbury</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>201 Morris Drive</b>		10f. Zip Code <b>21804</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Domestic</b>			
	17. Father's Name (First, Middle, Last) <b>Jesse Claude Morris</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Alice Mullins</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Robert M. Still (son)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>200 Morris Dr., Salisbury, MD 21804</b>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Salisbury Crematory</b>		20c. Location - City or Town, State <b>Salisbury, MD</b>		20d. Date <b>12/24/98</b>	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Holloway Funeral Home P.A. 501 Snow Hill Rd., Salisbury, MD 21804</b>			
	23a. (1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>Dementia</b> Due to (or as a consequence of):  b. <b>COPD</b> Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death  <b>4 yrs</b> <b>7 yrs</b>			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>HTN.</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier 				29c. License number <b>029349</b>		29d. Date signed (Month, Day, Year) <b>12/23/98</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>William H. Robins, M.D. - 1104 HEALTHWAY DR., SALISBURY, MD. 21804</b>							
To Be Completed by Physician/Medical Examiner	31. Date filed (Month, Day, Year) <b>DEC 28 1998</b>		32. Registrar's Signature 					
	State Registrar							



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 98 41206

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Richard William Strong Sr.

2. Date of Death  
Month Day Year  
DECEMBER 23, 19983. Time of Death  
6:52 P.M.

4a. Facility Name (If not institution, give street and number)

Sacred Heart Hospital

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

Funeral  
Director

5. Social Security Number

216-07-2303

6. Sex

10 M 20 F

7. Age (In yrs. last birthday)

88

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
10-21-1910

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Allegany

10c. City, Town or Location

Westernport

10d. Inside City Limits

10 Yes 20 No

10e. Street and Number

83 Spring Street

10f. Zip Code

21562

10g. Citizen of What Country?

United States

11. Marital Status

10 Never Married 20 Married  
30 Widowed 40 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
10 Yes 20 No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

10 Yes 20 No Specify:

14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (14 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

General Mechanic

16b. Kind of Business/Industry

Westvaco Corp.

17. Father's Name (First, Middle, Last)

John P. Strong

18. Mother's Name (First, Middle, Maiden Surname)

Ida Florence (Printy) Strong

19a. Informant's Name/Relationship (Type, Print)

Betty Wright - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

220 Roosevelt St. Westernport, MD 21562

20a. Method of Disposition

10 Burial 20 Cremation 30 Removal from State  
40 Donation 50 Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

St. Peter's Cemetery

Date

12-27-98 Westernport, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Fredlock Funeral Home

PO Box 4 Piedmont, West Virginia 26750

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Cardiac Shock

Approximate  
Interval Between  
Onset and Death

8 hours

Due to (or as a consequence of):

b. Acute Myocardial Infarction

1 day

Due to (or as a consequence of):

c. Coronary artery disease

20 years

Due to (or as a consequence of):

d. Arteriosclerotic cardiovascular disease

30 years

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

Transitory cell carcinoma of the urinary bladder

Abdominal Aortic aneurysm, Ruptured

23b. Did tobacco use contribute to the cause of death?

10 Yes 20 No 30 Probably 40 Unknown

24a. Was an autopsy  
performed?

10 Yes 20 No

24b. Were autopsy findings  
available prior to  
completion of cause  
of death?

10 Yes 20 No

25. Was case referred to medical  
examiner?

10 Yes 20 No

Hospital:

10 Inpatient 20 ER/Outpatient 30 DOA

26. Place of Death (Check only one)

Other: 40 Nursing Home 50 Residence 60 Other (Specify)

27. Manner of Death

10 Natural 50 Pending  
Investigation  
20 Accident 60 Could not be  
determined  
30 Suicide  
40 Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?

10 Yes 20 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)10 Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner as stated.

29b. Signature and title of certifier

29c. License number

D13601

29d. Date signed (Month, Day, Year)

12/23/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

V.R. Felipa, M.D., 925 Bishop Walsh Drive, Cumberland, MD 21502

31. Date filed (Month, Day, Year)

DEC 29 1998

32. Registrar's Signature

P. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41207

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Carl William Shipley S r

2. Date of Death

Dec 24 1998

3. Time of Death

10:30PM

4a. Facility Name (If not institution, give street and number)

Memorial Hospital

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

5. Social Security Number

212-38-7285

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

62

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 20, 1936

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Allegany

10c. City, Town or Location

Flintstone

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

12500 Murleys Branch Road NE

10f. Zip Code

21530

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Chief Maintenance

16b. Kind of Business/Industry

Dept Natural Resources

17. Father's Name (First, Middle, Last)

Ira Owen Shipley

18. Mother's Name (First, Middle, Maiden Surname)

Dorothy (Hymes)

19a. Informant's Name/Relationship (Type, Print)

Joyce M. Shipley--wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12500 Murleys Branch Road NE; Flintstone, MD 21530

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Glendale Cemetery

Date

12/28

20c. Location - City or Town, State

Flintstone, MD

21. Signature of Funeral Service Licensee

Nicholas J. Scarpelli

22. Name and Address of Facility

Scarpelli Funeral Home, P.A.  
Cumberland, MD 21502

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

a. Arteriosclerotic heart disease

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

uk yrs

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☒ Yes ☐ No

Hospital:

☐ Inpatient ☒ Outpatient ☐ DOA

26. Place of Death (Check only one)

Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Suicide  
☐ Homicide ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Paul Snow

Dpty Med Ex D 09157

29c. License number

29d. Date signed (Month, Day, Year)

Dec 24 1998

30. Name and address of person who completed causa of death (Item 23e) (Type, Print)

Paul Snow, M.D. 124 w 3rd st Cumb Md 21502

31. Date filed (Month, Day, Year)

DEC 29 1998

32. Registrar's Signature

Paul Snow

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

10

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 41208

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Charles Howard Stewart				2. Date of Death Month Day Year DECEMBER 25, 1998		3. Time of Death 2000														
	4a. Facility Name (If not institution, give street and number) Sacred Heart Hospital				4b. City, Town, or Location of Death Cumberland		4c. County of Death Allegany														
Funeral Director	5. Social Security Number 220-34-1650		8. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 92 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) June 21, 1906														
	9. Birthplace (State or Foreign Country) West Va.																				
Usual Residence of Decedent																					
10a. State Maryland			10b. County Allegany		10c. City, Town or Location Cumberland			10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No													
10e. Street and Number 217 Columbia Street					10f. Zip Code 21502		10g. Citizen of What Country? USA														
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White														
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Truck Driver			16b. Kind of Business/Industry Baking Company														
17. Father's Name (First, Middle, Last) Charles C. Stewart					18. Mother's Name (First, Middle, Maiden Surname) Josephine Batt																
19a. Informant's Name/Relationship (Type, Print) Mary Stewart/Wife					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 217 Columbia St. Cumberland, Md. 21502																
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Centenary Cemetery		Date 12/29/98		20c. Location - City or Town, State Cumberland, Md.														
21. Signature of Funeral Service Licensee Ernest A. Relyea					22. Name and Address of Facility Leasure-Stein Funeral Home 230 Baltimore Ave. Cumberland, Md. 21502																
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																					
<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. PNEUMONIA</td> <td>Due to (or as a consequence of):</td> <td>Approximate Interval Between Onset and Death 15 DAYS</td> </tr> <tr> <td>b. RESPIRATORY FAILURE</td> <td>Due to (or as a consequence of):</td> <td>15 DAYS</td> </tr> <tr> <td>c.</td> <td>Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d.</td> <td>Due to (or as a consequence of):</td> <td></td> </tr> </table>									Immediate Cause (Final disease or condition resulting in death)	a. PNEUMONIA	Due to (or as a consequence of):	Approximate Interval Between Onset and Death 15 DAYS	b. RESPIRATORY FAILURE	Due to (or as a consequence of):	15 DAYS	c.	Due to (or as a consequence of):		d.	Due to (or as a consequence of):	
Immediate Cause (Final disease or condition resulting in death)	a. PNEUMONIA	Due to (or as a consequence of):	Approximate Interval Between Onset and Death 15 DAYS																		
	b. RESPIRATORY FAILURE	Due to (or as a consequence of):	15 DAYS																		
	c.	Due to (or as a consequence of):																			
	d.	Due to (or as a consequence of):																			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ORGANIC BRAIN SYNDROME																					
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown																					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																					
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																					
26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No														
28d. Describe how injury occurred					28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)																
28f. Location (Street and Number or Rural Route Number, City or Town, State)																					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																					
29b. Signature and title of certifier Robert Welik MD					29c. License number D31875		29d. Date signed (Month, Day, Year) DECEMBER 26, 1998														
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert Welik MD, 902 Seton Drive Cumberland MD 21502																					
31. Date filed (Month, Day, Year) DEC 28 1998					32. Registrar's Signature [Signature]																

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41209

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JOHN ANTHONY SULLIVAN				2. Date of Death Month: DECEMBER Day: 26 Year: 1998		3. Time of Death 2:55 PM				
	4a. Facility Name (If not Institution, give street and number) 48 MARION STREET				4b. City, Town, or Location of Death CUMBERLAND		4c. County of Death ALLEGANY				
Funeral Director	5. Social Security Number 220-26-7689		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 67 Yrs.		8. Date of Birth (Month, Day, Year) MARCH 22 1931				
	9. Birthplace (State or Foreign Country) MARYLAND		10a. State MARYLAND		10b. County ALLEGANY		10c. City, Town or Location CUMBERLAND				
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 48 MARION STREET		10f. Zip Code 21502		10g. Citizen of What Country? U.S.A.				
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: KOREAN		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CELENESE CORP OF AMERICA		16b. Kind of Business/Industry SILK/MANUF.						
	17. Father's Name (First, Middle, Last) ANDREW BENJAMIN SULLIVAN				18. Mother's Name (First, Middle, Maiden Surname) ELIZABETH ELLEN JOHNSON						
	19a. Informant's Name/Relationship (Type, Print) ANNA MAE RANDALL COMPANION				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 48 MARION STREET CUMBERLAND MARYLAND 21502						
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) ROCKY GAP VET CEMETERY DEC 29 1998 FLINTSTONE MD.		20c. Location - City or Town, State						
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
	<table border="1"> <tr> <td rowspan="4">                 Immediate Cause (Final disease or condition resulting in death)                   e. ARTERIOSCLEROTIC HEART DISEASE                  Due to (or as a consequence of):                  b. _____                  Due to (or as a consequence of):                  c. _____                  Due to (or as a consequence of):                  d. _____             </td> <td colspan="2">                 Approximate Interval Between Onset and Death                  UNKNOWN YEARS             </td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)  e. ARTERIOSCLEROTIC HEART DISEASE Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____	Approximate Interval Between Onset and Death UNKNOWN YEARS	
	Immediate Cause (Final disease or condition resulting in death)  e. ARTERIOSCLEROTIC HEART DISEASE Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____	Approximate Interval Between Onset and Death UNKNOWN YEARS									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown											
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No											
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No											
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)											
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined											
28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 28d. Describe how Injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)											
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier  29c. License number D 09159 29d. Date signed (Month, Day, Year) DECEMBER 26, 1998											
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR PAUL SNOW 124 WEST 3rd STREET CUMBERLAND MARYLAND 21502											
31. Date filed (Month, Day, Year) DEC 28 1998 32. Registrar's Signature 											

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



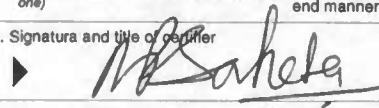
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41210

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>DAVID L. SANFORD</b>				2. Date of Death Month <b>December</b> Day <b>21</b> , Year <b>1998</b>		3. Time of Death <b>5:00A.M.</b>	
	4a. Facility Name (If not Institution, give street and number) <b>66 W. College Avenue</b>				4b. City, Town, or Location of Death <b>Frostburg</b>		4c. County of Death <b>Allegheny</b>	
Funeral Director	5. Social Security Number <b>235-48-1987</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>65</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Feb. 5 1933</b>	
	9. Birthplace (State or Foreign Country) <b>West Virginia</b>		10a. State <b>Maryland</b>		10b. County <b>Allegheny</b>		10c. City, Town or Location <b>Frostburg</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>66 W. College Avenue</b>		10f. Zip Code <b>21532</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>Korea</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>6</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Dean</b>		16b. Kind of Business/Industry <b>University</b>			
	17. Father's Name (First, Middle, Last) <b>Harry E. Sanford</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Ethel Gilbert</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Mary Elizabeth Sanford</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>66 W. College Ave. Frostburg, Md. 21532</b>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Cumberland Crematory</b>		20c. Date <b>12/22/98</b>		20d. Location - City or Town, State <b>Cumberland, Md.</b>	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Durst Funeral Home P.A. 57 Frost Avenue Frostburg, Md. 21532</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. <b>Dilated Ischemic Cardiomyopathy 23 years</b> Due to (or as a consequence of):							
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.							
	Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.							
Medical Certification: To Be Completed by Physician/Medical Examiner	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
			28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier 				29c. License number <b>D 17920</b>		29d. Date signed (Month, Day, Year) <b>12-21-1998</b>	
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>DR. NARAYAN SAHETA 600 MEMORIAL AVENUE CUMBERLAND, MD. 21502</b>							
State Registrar	31. Date filed (Month, Day, Year) <b>DEC 22 1998</b>				32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Amended # 206 N.H.S.  
12/23/98, Allegany County

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 41211

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JAMES WILLIAM SIMPSON</b>				2. Date of Death Month Day Year <b>December 19, 1998</b>		3. Time of Death <b>2240p.m.</b>
	4a. Facility Name (If not institution, give street and number) <b>SACRED HEART HOSPITAL</b>				4b. City, Town, or Location of Death <b>CUMBERLAND</b>		4c. County of Death <b>ALLEGANY</b>
Funeral Director	5. Social Security Number <b>215-14-6005</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>77</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>MAY 5, 1921</b>	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>
	Usual Residence of Decedent						
To Be Completed by Funeral Director	10a. State <b>MD</b>	10b. County <b>ALLEGANY</b>	10c. City, Town or Location <b>CUMBERLAND</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number <b>805 WASHINGTON STREET</b>			10f. Zip Code <b>21502</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>W.W.II</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> <b>4</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>CHIEF RADIO OPERATOR</b>		16b. Kind of Business/Industry <b>DEPT. OF NAVY U.S. GOVERNMENT</b>		
	17. Father's Name (First, Middle, Last) <b>AUGUST P. SIMPSON</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>MARY BUCY</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>KAREN LaROSA / DAUGHTER</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9108 ALDERSHOT DRIVE, BETHESDA, MD 20817</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>HILLCREST BURIAL PARK</b>		20c. Location - City or Town, State <b>CUMBERLAND, MD</b>		
	21. Signature of Funeral Service Licensee <i>Shirley D. Lockwood</i>		22. Name and Address of Facility <b>UPCHURCH FUNERAL HOME, P.A. 202 GREENE ST., CUMBERLAND, MD 21502</b>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Squamous Cell Carcinoma of Lung 9 mo.</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>						
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Pleural effusion</b>						
State Registrar	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred				
	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
7 N.S.	29b. Signature and Title of certifier <i>Paul J. Livengood MD</i>		29c. License number <b>D 23774</b>		29d. Date signed (Month, Day, Year) <b>December 22 1998</b>		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>PAUL T. LIVENGOOD MD 912 SETON DR CUMBERLAND MD</b>						
31. Date filed (Month, Day, Year) <b>DEC 22 1998</b>		32. Registrar's Signature <i>[Signature]</i>					





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 41212

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Mary Clise Simms</b>				2. Date of Death Month <b>12</b> Day <b>19</b> Year <b>1998</b>		3. Time of Death <b>1:00 pm</b>		
	4a. Facility Name (If not institution, give street and number) <b>Egle Nursing Home</b>				4b. City, Town, or Location of Death <b>Lonaconing</b>		4c. County of Death <b>Allegany</b>		
Funeral Director	5. Social Security Number <b>579-22-4003</b>		6. Sex <b>1</b> <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>80</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>05-17-18</b>	9. Birthplace (State or Foreign Country) <b>MD</b>	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State <b>MD</b>		10b. County <b>Allegany</b>		10c. City, Town or Location <b>Frostburg</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>11515 Kenner Lane S.W.</b>				10f. Zip Code <b>21532</b>		10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status <b>3</b> <input checked="" type="checkbox"/> Widowed <b>4</b> <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Home</b>				
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>John Henry Clise</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Tinnie Beeman</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>Mary Ann Kenner Niece</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>21532</b> <b>15119 New Georges Creek Road, S.W., Frostburg, MD</b>				
	20a. Method of Disposition <b>1</b> <input checked="" type="checkbox"/> Burial <b>2</b> <input type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State <b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Oak Grove Methodist Cemetery</b>		Date <b>Dec. 22 1998</b>		20c. Location - City or Town, State <b>Aylor, VA</b>		
	21. Signature of Funeral Service Licensee <b>Joe E. McKee</b>		22. Name and Address of Facility <b>Eichhorn-McKenzie Funeral Home P.A.</b> <b>8 East Main Street, Lonaconing 21539</b>						
Physician /Medical Examiner	23a. Pertinent. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. CORONARY ARTERY DISEASE</b> Due to (or as a consequence of):  <b>b.</b> Due to (or as a consequence of):  <b>c.</b> Due to (or as a consequence of):  <b>d.</b> Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death <b>Approx 10 years</b>	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CONGESTIVE HEART FAILURE</b> <b>CHRONIC OBSTRUCTIVE LUNG DISEASE</b> <b>Peripheral vascular disease</b>							23b. Did tobacco use contribute to the cause of death? <b>1</b> <input type="checkbox"/> Yes <b>2</b> <input type="checkbox"/> No <b>3</b> <input type="checkbox"/> Probably <b>4</b> <input checked="" type="checkbox"/> Unknown	
	24a. Was an autopsy performed? <b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? <b>1</b> <input type="checkbox"/> Yes <b>2</b> <input type="checkbox"/> No	
	25. Was case referred to medical examiner? <b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <b>1</b> <input type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA Other: <b>4</b> <input checked="" type="checkbox"/> Nursing Home <b>5</b> <input type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify)						
27. Manner of Death <b>1</b> <input checked="" type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending Investigation <b>2</b> <input type="checkbox"/> Accident <b>6</b> <input type="checkbox"/> Could not be determined <b>3</b> <input type="checkbox"/> Suicide <b>4</b> <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of injury <b>M</b>		28c. Injury at Work? <b>1</b> <input type="checkbox"/> Yes <b>2</b> <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <b>1</b> <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Hedh</b>		29c. License number <b>D 26907</b>		29d. Date signed (Month, Day, Year) <b>DECEMBER 19, 1998</b>			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Harjit S. Sidhu 925 Bishop Walsh Road, Cumberland, MD 21502</b>									
31. Date filed (Month, Day, Year) <b>DEC 21 1998</b>		32. Registrar's Signature <b>[Signature]</b>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

100-111111-1

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41213

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>George Marvin Smith</b>				2. Date of Death Month Day Year <b>Dec 16, 1998</b>				3. Time of Death <b>11:45 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>7200 Kipling Parkway</b>				4b. City, Town, or Location of Death <b>District Heights</b>				4c. County of Death <b>Prince George's</b>	
Funeral Director	5. Social Security Number <b>577-22-9147</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>74</b> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) <b>March 25, 1924</b>		9. Birthplace (State or Foreign Country) <b>Washington DC</b>		10a. State <b>MD</b>		10b. County <b>P.G.</b>		10c. City, Town or Location <b>District Heights</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>7200 Kipling Parkway</b>		10f. Zip Code <b>20747</b>		10g. Citizen of What Country? <b>United States</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1944 1959</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>2</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>1st Sgt.</b>		16b. Kind of Business/Industry <b>U.S. Air Force</b>					
	17. Father's Name (First, Middle, Last) <b>Charles Edward Smith</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Ella Burdge Munsetter</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Charles R. Smith (SON)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2220 South Lumber Street, Allentown, Pa. 18103</b>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Dec 23, 1998</b> <b>Arlington National Cemetery</b>		20c. Location - City or Town, State <b>Arlington, Virginia</b>					
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735</b>							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  e. <b>Cardio- Pulmonary Arrest</b> Due to (or as a consequence of):  b. <b>Lung Cancer</b> Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):		Approximate Interval Between Onset and Death							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>D0052965</b>		29d. Date signed (Month, Day, Year) <b>Dec 16, 1998</b>			
State Registrar	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>NNMC, Bldg 8 3RD Floor Sattva Swarup Neelapu, 8901 Wisconsin Ave, Bethesda, MD 20889</b>				31. Date filed (Month, Day, Year) <b>DEC 22 1998</b>				32. Registrar's Signature 	

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

20+1

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 4 12 14

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ANGELA MARIE SIPE				2. Date of Death Month Day Year DECEMBER 15, 1998		3. Time of Death 0147 AM				
	4a. Facility Name (If not institution, give street and number) 6547 HILLMAR DRIVE				4b. City, Town, or Location of Death FORRESTVILLE		4c. County of Death PRINCE GEORGES				
Funeral Director	5. Social Security Number 213 21 7378		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 27 Yrs.		8. Date of Birth (Month, Day, Year) Feb 5, 1971		9. Birthplace (State or Foreign Country) Wash., D.C.		
	Usual Residence of Decedent										
10a. State Maryland		10b. County Calvert		10c. City, Town or Location Chesapeake Beach				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
10e. Street and Number 7626 C Street				10f. Zip Code 20732		10g. Citizen of What Country? USA					
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) none			16b. Kind of Business/Industry				
17. Father's Name (First, Middle, Last) John Francis Grim				18. Mother's Name (First, Middle, Maiden Surname) Carol Ann Shriver							
19a. Informant's Name/Relationship (Type, Print) Carol A. Grim / mother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) same as # 10 above							
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery		Date 12-18-98		20c. Location - City or Town, State Suitland, MD				
21. Signature of Funeral Service Licensee William R. Jones				22. Name and Address of Facility Rausch Funeral Home, P.A., Owings, MD 20736							
Physician /Medical Examiner	23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Multiple Gunshot Wounds Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? XXX Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) AT SCENE							
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year) 12/15/98 Found		28b. Time of Injury 0147 M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred Subject shot	
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Building; Stairwell of 6547 Hillmar Dr; Forrestville, Md				28b. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of his knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. XX Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier J. Pestaner, M.D.				29c. License number OCME		29d. Date signed (Month, Day, Year) DECEMBER 15, 1998	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201											
31. Date filed (Month, Day, Year) DEC 21 1998				32. Registrar's Signature B. Sparks							





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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41215

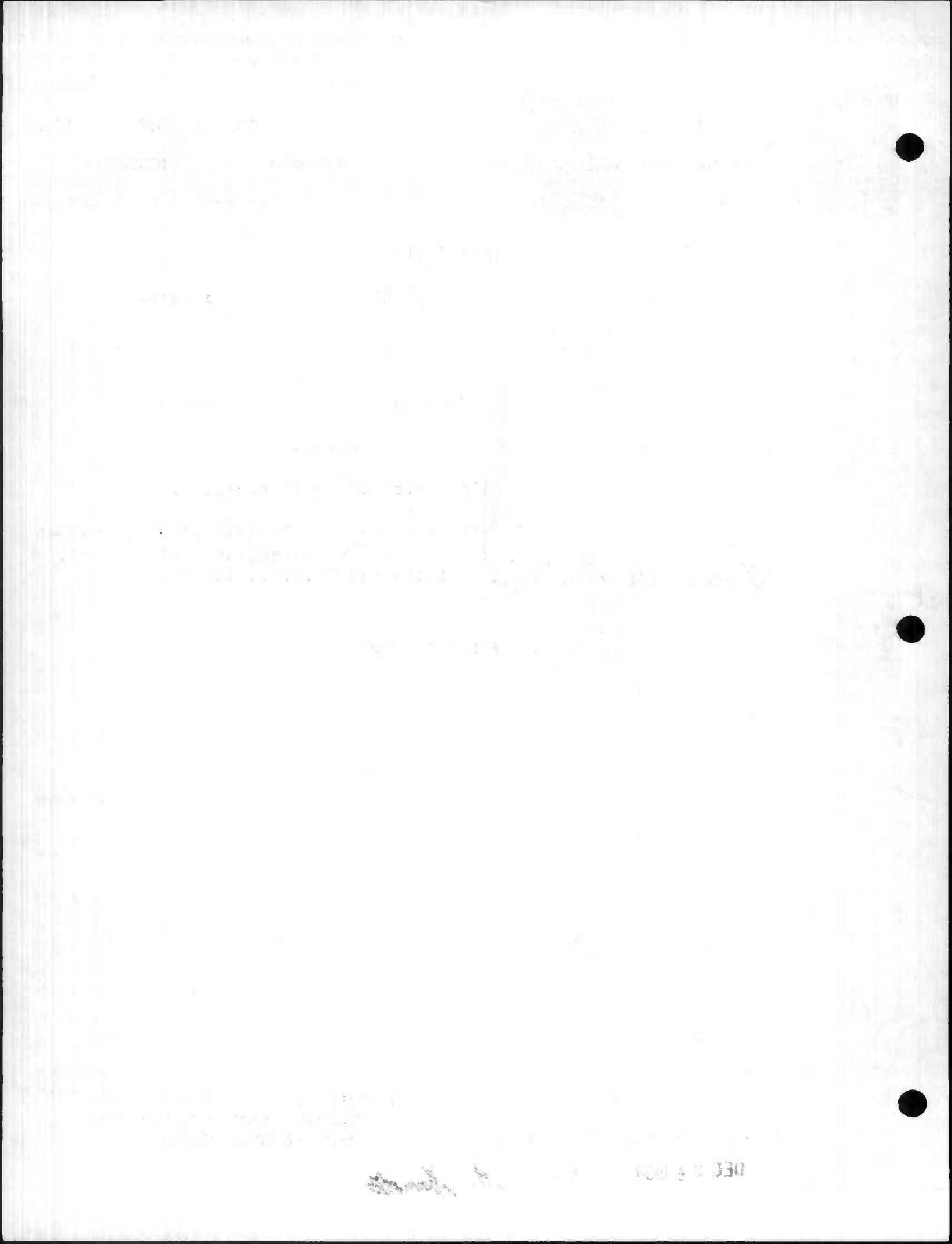
<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>ALI PASHA SHOUKAT</b>					2. Date of Death Month <b>DEC</b> Day <b>22</b> Year <b>1998</b>		3. Time of Death <b>5:01 PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>NATIONAL NAVAL MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>BETHESDA</b>		4c. County of Death <b>MONTGOMERY</b>			
<b>Funeral Director</b>	5. Social Security Number <b>226-81-0454</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>73</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>12-24-24</b>		9. Birthplace (State or Foreign Country) <b>Pakistan</b>	
	Usual Residence of Decedent									
10a. State <b>VA.</b>		10b. County <b>Fairfax</b>		10c. City, Town or Location <b>Springfield</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>8622 Arley Dr.</b>				10f. Zip Code <b>22152</b>		10g. Citizen of What Country? <b>Pakistan</b>				
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify <b>Pakistani</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Merchant</b>			16b. Kind of Business/Industry <b>Unknown</b>			
17. Father's Name (First, Middle, Last) <b>Muhammad Ali</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Unknown</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Mahmood Shoukat</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8622 Arley Dr, Springfield, Va. 22152</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Family Cemetery</b>		Date <b>12-28-98</b>		20c. Location - City or Town, State <b>Lahore, Pakistan</b>			
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility <b>UNIVERSAL MORTUARY INC. 411 Kennedy St, N.W., Wash, D.C.</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death
<div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p><b>CORONARY ARTERY DISEASE</b></p> <p>Due to (or as a consequence of):</p> </div> <div style="width: 60%;"> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</p> <p><b>a. Due to (or as a consequence of):</b></p> <p><b>b. Due to (or as a consequence of):</b></p> <p><b>c. Due to (or as a consequence of):</b></p> <p><b>d. Due to (or as a consequence of):</b></p> </div> </div>										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier 					29c. License number <b>GFE 79711 (CA)</b>		29d. Date signed (Month, Day, Year) <b>DECEMBER 23, 1998</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Daniel L. Gramins, LT, MC, USNR</b>					<b>NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600</b>					
31. Date filed (Month, Day, Year) <b>DEC 24 1998</b>			32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar





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State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

Reg. No.

98 41216

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JAMES K. SULLIVAN</b>				2. Date of Death Month Day Year <b>DECEMBER 17th 1998</b>		3. Time of Death <b>8:A.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>COLLINGSWOOD NURSING &amp; REHABILITATION CTR.</b>				4b. City, Town, or Location of Death <b>ROCKVILLE</b>		4c. County of Death <b>MONTGOMERY</b>	
Funeral Director	5. Social Security Number <b>573-36-1122</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>77</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Sept. 13, 1921</b>		9. Birthplace (State or Foreign Country) <b>Texas</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>Md.</b>	10b. County <b>P.G.</b>	10c. City, Town or Location <b>Glenarden</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <b>8619 Glenarden Pkwy.</b>			10f. Zip Code <b>20706</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Not given</b>		16b. Kind of Business/Industry <b>Not given</b>			
	17. Father's Name (First, Middle, Last) <b>Not given</b>				18. Mother's Name (First, Middle, Maiden Summa) <b>Not Given</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Courtney Hewlett/Guardian</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8619 Glenarden Pkwy, Glenarden Md. 20706</b>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Arlington Nat. Cem</b>		Data <b>1/5/99</b>		20c. Location - City or Town, State <b>Arlington, Va.</b>	
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility <b>Johnson &amp; Jenkins Inc, 716 Kennedy St. N.W. Wash. D.C. 20011</b>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. MYOCARDIAL INFARCTION</b> Due to (or as a consequence of):  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>							Approximate Interval Between Onset and Death <b>1/2 hour</b>
	Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. <b>CVA, ARTHRITIS, DEMENTIA, HTN</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Physician		29c. License number <b>000053529</b>		29d. Date signed (Month, Day, Year) <b>December 17, 1998</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>2309 Shorefield Road Wheaton, MD 20878</b>								
31. Date filed (Month, Day, Year) <b>DEC 21 1998</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

State  
Registrar

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State of Maryland / Department of Health and Mental Hygiene

98 41217

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>FLORENCE E. STEWART</b>				2. Date of Death Month Day Year <b>DECEMBER 15, 1998</b>		3. Time of Death <b>1350</b>	
	4a. Facility Name (If not institution, give street and number) <b>ANNE ARUNDEL MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>ANNAPOLIS</b>		4c. County of Death <b>ANNE ARUNDEL COUNTY</b>	
Funeral Director	5. Social Security Number <b>577-26-3625</b>	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>95</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>NOV. 8, 1903</b>		9. Birthplace (State or Foreign Country) <b>WASHINGTON, DC</b>
	Usual Residence of Decedent							
10a. State <b>MARYLAND</b>		10b. County <b>ANNE ARUNDEL</b>		10c. City, Town or Location <b>EDGEWATER</b>			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number <b>2923 MAIN STREET</b>				10f. Zip Code <b>21037</b>		10g. Citizen of What Country? <b>UNITED STATES</b>		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12+</b> College (14 or 5+) <b>CLERK</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>CLERK</b>			16b. Kind of Business/Industry <b>SALES</b>	
17. Father's Name (First, Middle, Last) <b>LILLO V. McKENNEY</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>BLANCHE E. TREAKLE</b>				
19a. Informant's Name/Relationship (Type, Print) <b>JUNE E. SPRADLIN, DAUGHTER</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2923 MAIN STREET, EDGEWATER, MARYLAND 21037</b>				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>FORT LINCOLN CEMETERY</b>		20c. Date <b>12/18/98</b>		20d. Location - City or Town, State <b>BRENTWOOD, MARYLAND</b>		
21. Signature of Funeral Service Licensee <i>Lise S. Johnson</i>				22. Name and Address of Facility <b>FORT LINCOLN FUNERAL HOME</b> <b>3401 BLADENSBURG RD., BRENTWOOD, MARYLAND 20722</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>ACUTE RENAL FAILURE</b> Due to (or as a consequence of): b. <b>Ruptured Abdominal Viscera</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death <b>1 wk</b> <b>1 wk</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>John D. Jackson MD</i>		29c. License number <b>276718</b>		29d. Date signed (Month, Day, Year) <b>12-21-98</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>John D. Jackson, MD 2003 Medical Plaza, Annapolis, MD 21401</b>								
31. Date filed (Month, Day, Year) <b>DEC 21 1998</b>		32. Registrar's Signature <i>[Signature]</i>						

ORIGINAL

DEC 8 1986

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41218

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Eula Scott</b>				2. Date of Death Month Day Year <b>December 22, 1998</b>				3. Time of Death <b>12:24 p.m.</b>																								
	4a. Facility Name (If not Institution, give street and number) <b>Pleasant View Nursing Home</b>				4b. City, Town, or Location of Death <b>Mt. Airy</b>				4c. County of Death <b>Carroll</b>																								
Funeral Director	5. Social Security Number <b>487-28-1314</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>100</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>May 19, 1898</b>		9. Birthplace (State or Foreign Country) <b>Haynesville Louisiana</b>																								
	Usual Residence of Decedent																																
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>Prince George's</b>		10c. City, Town or Location <b>Suitland</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No																								
	10e. Street and Number <b>3908 Stonegate Drive, Apt # B</b>				10f. Zip Code <b>20746</b>		10g. Citizen of What Country? <b>U.S.A.</b>																										
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>																									
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6th</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Cook</b>			16b. Kind of Business/Industry <b>Private</b>																									
	17. Father's Name (First, Middle, Last) <b>Monroe Henderson</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Henderson</b>																												
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Harry J. Scott/Grandson</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3908 Stonegate Drive, #B, Suitland, Maryland 20746</b>																												
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Harmony Memorial Park</b>		Date <b>12/28 1998</b>		20c. Location - City or Town, State <b>Landover, Maryland</b>																										
	21. Signature of Funeral Service Licensee <b>Nancy A. Perentie</b>				22. Name and Address of Facility <b>J. B. JENKINS FUNERAL HOME 7474 Landover Road, Landover, Maryland 20785</b>																												
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																																
	23b. Approximate Interval Between Onset and Death																																
<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a.</td> <td><b>Cardiac Arrest</b></td> <td>minutes</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>b.</td> <td><b>Cardiac Atherosclerosis</b></td> <td>years</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td rowspan="2">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>c.</td> <td><b>General Atherosclerosis</b></td> <td>years</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td colspan="2">d.</td> <td></td> <td></td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death)	a.	<b>Cardiac Arrest</b>	minutes	Due to (or as a consequence of):			b.	<b>Cardiac Atherosclerosis</b>	years	Due to (or as a consequence of):			Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	<b>General Atherosclerosis</b>	years	Due to (or as a consequence of):			d.			
Immediate Cause (Final disease or condition resulting in death)	a.	<b>Cardiac Arrest</b>	minutes																														
	Due to (or as a consequence of):																																
	b.	<b>Cardiac Atherosclerosis</b>	years																														
	Due to (or as a consequence of):																																
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	<b>General Atherosclerosis</b>	years																														
	Due to (or as a consequence of):																																
d.																																	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Cerebral vascular accident. Dementia</b> <b>Atrial Fibrillation</b>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown																									
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																									
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																									
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																															
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred																									
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)																															
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Melvin Joel Kordum MD</b>		29c. License number <b>006588</b>		29d. Date signed (Month, Day, Year) <b>12/22/98</b>																											
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>4801 Dorsey Hall Drive Suitland City Maryland 21044</b>																																	
State Registrar	31. Date filed (Month, Day, Year) <b>DEC 23 1998</b>		32. Registrar's Signature 																														

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

3

DEC 8 1930



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41219

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last) <b>Anna Mary Elizabeth Millender Tracey</b>				2. Date of Death Month Day Year <b>Dec 18, 1998</b>		3. Time of Death <b>3:15 am</b>	
4a. Facility Name (If not institution, give street and number) <b>4017 Shiloh Avenue</b>				4b. City, Town, or Location of Death <b>Hampstead</b>		4c. County of Death <b>Carroll</b>	
5. Social Security Number <b>220-01-2230</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>85</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Sep 27, 1913</b>	
9. Birthplace (State or Foreign Country) <b>Maryland</b>							
Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Carroll</b>		10c. City, Town or Location <b>Hampstead</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>4017 Shiloh Avenue</b>				10f. Zip Code <b>21074</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Housewife</b>		16b. Kind of Business/Industry <b>Own Home</b>	
17. Father's Name (First, Middle, Last) <b>Daniel Howard Millender</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Annie Elizabeth Ruby</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Betty Bollinger, daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1611 St. Paul St, Hampstead, MD 21074</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Hampstead Cemetery</b>		Date <b>12/21</b>		20c. Location - City or Town, State <b>Hampstead, MD</b>	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Eline Funeral Home 934 South Main St, Hampstead, MD 21074</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Metastatic Adenocarcinoma</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.							Approximate Interval Between Onset and Death <b>1 month</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
						24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>D33165</b>		29d. Date signed (Month, Day, Year) <b>12/21/98</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Steven Shaffer 2111 Hanover Pike Hampstead MD 21074</b>							
31. Date filed (Month, Day, Year) <b>DEC 22 1998</b>		32. Registrar's Signature 					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41220

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Robert LeRoy Tabler

2. Date of Death

Month Day Year  
December 21, 1998

3. Time of Death

5:00AM

4e. Facility Name (If not institution, give street and number)

6900 Stratford Drive

4b. City, Town, or Location of Death

Sykesville

4c. County of Death

Carroll

Funeral  
Director

5. Social Security Number

220 - 16 - 0880

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Jun 8, 1911

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Carroll

10c. City, Town or Location

Sykesville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6900 Stratford Drive

10f. Zip Code

21784

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Chief Engineer

16b. Kind of Business/Industry

State of Maryland

17. Father's Name (First, Middle, Last)

Robert L. Tabler

18. Mother's Name (First, Middle, Maiden Surname)

Ella Duval

19a. Informant's Name/Relationship (Type, Print)

Agnes H. Tabler/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6900 Stratford Drive Sykesville, Maryland 21784

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Evergreen Memorial Gardens

Date

12/23/98

20c. Location - City or Town, State

Finksburg Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Jeffrey N. Zumbrun Funeral Home & Monument Co.  
6028 Sykesville Road Eldersburg, Maryland 21784

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Congestive Heart Failure

Due to (or as a consequence of):

b.

Coronary Artery Disease

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Three years

Five years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Atrial Fibrillation

Pulmonary Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ OOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D33184

29d. Date signed (Month, Day, Year)

December 21, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Jonathan Kushner 114 Business Center Drive Reisterstown, Maryland 21136

31. Date filed (Month, Day, Year)

DEC 22 1998

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41221

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Catherine Mary Therres				2. Date of Death Month Day Year December 27, 1998		3. Time of Death 10:05 PM	
	4a. Facility Name (If not Institution, give street and number) 7210 Benedict Avenue				4b. City, Town, or Location of Death Benedict		4c. County of Death Charles	
Funeral Director	5. Social Security Number 215-38-4868		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 90 Yrs.		8. Date of Birth (Month, Day, Year) March 2, 1908	
	9. Birthplace (State or Foreign Country) Wisconsin		10a. State Maryland		10b. County Charles		10c. City, Town or Location Benedict	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number 7210 Benedict Avenue		10f. Zip Code Benedict	
	10g. Citizen of What Country? USA				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry Own Home			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Wenzel Koller				18. Mother's Name (First, Middle, Maiden Surname) Mary Koller			
	19a. Informant's Name/Relationship (Type, Print) Anna L. Stonestreet-Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6478 Oak Hill Place, Bryantown, MD. 20617			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify):				20b. Place of Disposition (Name of cemetery, crematory or other place) St. Mary's Cemetery		20c. Location - City or Town, State 12-31-98 Bryantown, MD	
	21. Signature of Funeral Service Licensee David A. Goff M01095				22. Name and Address of Facility Huntt Funeral Home, Inc. P. O. Box 156, Waldorf, MD 20604-0156			
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cardiac failure Due to (or as a consequence of): b. Hypertensive Heart Disease Due to (or as a consequence of): c. Hypertension Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Coronary Heart Disease							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
To Be Completed by Physician/Medical Examiner	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 8 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							29b. Signature and title of certifier hsnath
	29c. License number 012587		29d. Date signed (Month, Day, Year) 12-29-98					
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) G. Shankar Rath, 7C Post Office Road, Waldorf, MD 20602							
	31. Date filed (Month, Day, Year) DEC 31 1998				32. Registrar's Signature B. Sparks			





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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41222

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) John Linville Thomason				2. Date of Death Month Day Year December 18, 1998				3. Time of Death 11:50 am	
	4a. Facility Name (If not institution, give street and number) St. Mary's Nursing Center				4b. City, Town, or Location of Death Leonardtwn				4c. County of Death St. Mary's	
Funeral Director	5. Social Security Number 215-18-0357		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (in yrs. last birthday) 76 Yrs.		8. Date of Birth (Month, Day, Year) April 27, 1922		9. Birthplace (State or Foreign Country) Virginia	
	Usual Residence of Decedent									
10a. State Maryland		10b. County St. Mary's		10c. City, Town or Location Avenue				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 23192 Colton Point Road				10f. Zip Code 20609				10g. Citizen of What Country? U.S.A.		
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11th College (1-4or 5+) 11th				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Farmer				16b. Kind of Business/Industry Farm		
17. Father's Name (First, Middle, Last) John Leslie Thomason					18. Mother's Name (First, Middle, Maiden Surname) Nannie Linville					
19a. Informant's Name/Relationship (Type, Print) Madge Ebner/Sister					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23192 Colton Point Road, Avenue, MD 20609					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) St. Paul's Methodist Cemetery		Date 12/21/98		20c. Location - City or Town, State Leonardtwn, Maryland			
21. Signature of Funeral Service Licensee <i>Michael Kern Gardiner</i>					22. Name and Address of Facility Matingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) Failure of major organ systems  Due to (or as a consequence of): Pulmonary (lung) carcinoma  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):									Approximate Interval Between Onset and Death one day  6 mos	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension									23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier <i>[Signature]</i>					29c. License number DC2159		29d. Date signed (Month, Day, Year) December 21, 1998			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eugene S. [Signature] Chaptico, Maryland 20621										
31. Date filed (Month, Day, Year) DEC 21 1998					32. Registrar's Signature <i>[Signature]</i>					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41223

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>Marie Thompson</b>					2. Date of Death Month Day Year <b>Dec. 24, 1998</b>			3. Time of Death <b>12:50 PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>Moran Manor Nursing Home</b>					4b. City, Town, or Location of Death <b>Westernport</b>			4c. County of Death <b>Allegany</b>		
<b>Funeral Director</b>	5. Social Security Number <b>236-20-9013</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>96</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Jul 12, 1902</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		
	Usual Residence of Decedent										
<b>To Be Completed by Funeral Director</b>	10a. State <b>MD</b>		10b. County <b>Allegany</b>		10c. City, Town or Location <b>Westernport</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	10e. Street and Number <b>25701 Shady Lane</b>				10f. Zip Code <b>21562</b>		10g. Citizen of What Country? <b>USA</b>				
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>white</b>			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>			16b. Kind of Business/Industry <b>Own Home</b>				
	17. Father's Name (First, Middle, Last) <b>Ed Gillespie</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Anna Luciene</b>					
<b>To Be Completed by Physician/Medical Examiner</b>	19a. Informant's Name/Relationship (Type, Print) <b>Joseph Thompson--son</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>24602 Doberman Dr SW Westernport MD 21562</b>					
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>St. Peter's Cemetery</b>			Date <b>12/98</b>		20c. Location - City or Town, State <b>Cumberland</b>			
	21. Signature of Funeral Service Licensee 					22. Name and Address of Facility <b>Fredlock Funeral Home Piedmont, WV 26750</b>					
	23a. Part I. Enter the disease, or complications that caused this death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>Immediate Cause (Final disease or condition resulting in death) a. <b>Generalized Sepsis</b> Due to (or as a consequence of):</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d.</p> </div> <div style="width: 15%; text-align: center;"> <p>Approximate Interval Between Onset and Death <b>1 week</b></p> </div> </div>										
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Coronary Artery Disease</b>								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> <b>Certifying Physician:</b> To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> <b>Medical Examiner:</b> On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier 					29c. License number <b>D21244</b>			29d. Date signed (Month, Day, Year) <b>DECEMBER 26 1998</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Jesus Tan, M.D. Frostburg Plaza Frostburg MD 21532</b>											
31. Date filed (Month, Day, Year) <b>DEC 29 1998</b>					32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41224

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Eugene Earl Tolson				2. Date of Death Month Day Year Dec 13, 1998				3. Time of Death 2:18 AM				
	4a. Facility Name (If not institution, give street and number) Southern MD Hospital Center				4b. City, Town, or Location of Death Clinton				4c. County of Death Prince Georges				
Funeral Director	5. Social Security Number 577 44 4461		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 67 Yrs.		8. Date of Birth (Month, Day, Year) Sept 1, 1931		9. Birthplace (State or Foreign Country) Maryland				
	Usual Residence of Decedent				10a. State MD				10b. County P.G.		10c. City, Town or Location Clinton		
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number 9805 Brandywine Road				10f. Zip Code 20735		10g. Citizen of What Country? United States			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Seafood Restraunt				16b. Kind of Business/Industry Self Employed					
17. Father's Name (First, Middle, Last) Alfred Raymond Tolson				18. Mother's Name (First, Middle, Maiden Summe) Nellie Helen Bowish									
19a. Informant's Name/Relationship (Type, Print) Nancy Tolson (WIFE)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9805 Brandywine Road, Clinton, Maryland 20735									
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Lee Crematory Dec 19, 1998				20c. Location - City or Town, State Clinton, Maryland					
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735									
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Cardiac Arrhythmia</u> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last												Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Coronary Artery Disease</u>													
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown													
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No													
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No													
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. Signature and title of certifier 				29c. License number D-0053713				29d. Date signed (Month, Day, Year) 12-15-98					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas Hanson 5268 Daves Ave Alexandria VA													
31. Date filed (Month, Day, Year) DEC 17 1998				32. Registrar's Signature 									

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-d show injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41225

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Robert Bernard Taylor				2. Date of Death Month Day Year Dec 21 1998		3. Time of Death 11:45 PM	
	4a. Facility Name (If not institution, give street and number) St. Agnes Healthcare				4b. City, Town, or Location of Death Baltimore		4c. County of Death	
Funeral Director	5. Social Security Number 579-05-8118		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 79 Yrs.		8. Date of Birth (Month, Day, Year) Dec. 19, 1919	
	9. Birthplace (State or Foreign Country) Wash., D.C.		10a. State District of Columbia		10b. County Washington		10c. City, Town or Location Washington	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				10e. Street and Number 1440 Rock Creek Ford Rd.; #T13		10f. Zip Code 20011	
	10g. Citizen of What Country? United States				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:	
	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: African American		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Businessman				16b. Kind of Business/Industry Self-Employed			
	17. Father's Name (First, Middle, Last) Robert Taylor				18. Mother's Name (First, Middle, Maiden Surname) Georgia Johnson			
	19a. Informant's Name/Relationship (Type, Print) Evelyn Taylor - Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1440 Rock Creek Ford R., #T13; Wash., D.C. 20011			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Lincoln Memorial Cem.		20c. Location - City or Town, State Suitland, MD	
	21. Signature of Funeral Service Licensee John T. Stewart III				22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Lung Cancer				Approximate Interval Between Onset and Death 1 year			
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
		28d. Describe how injury occurred		28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify)				
		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier MUTOMBO KANKONDE, MD				29c. License number D46704		29d. Date signed (Month, Day, Year) Dec 21, 1998		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MUTOMBO KANKONDE, ST AGNES HOSPITAL, BLT, MD								
31. Date filed (Month, Day, Year) DEC 24 1998		32. Registrar's Signature						

DEC 5 1960



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

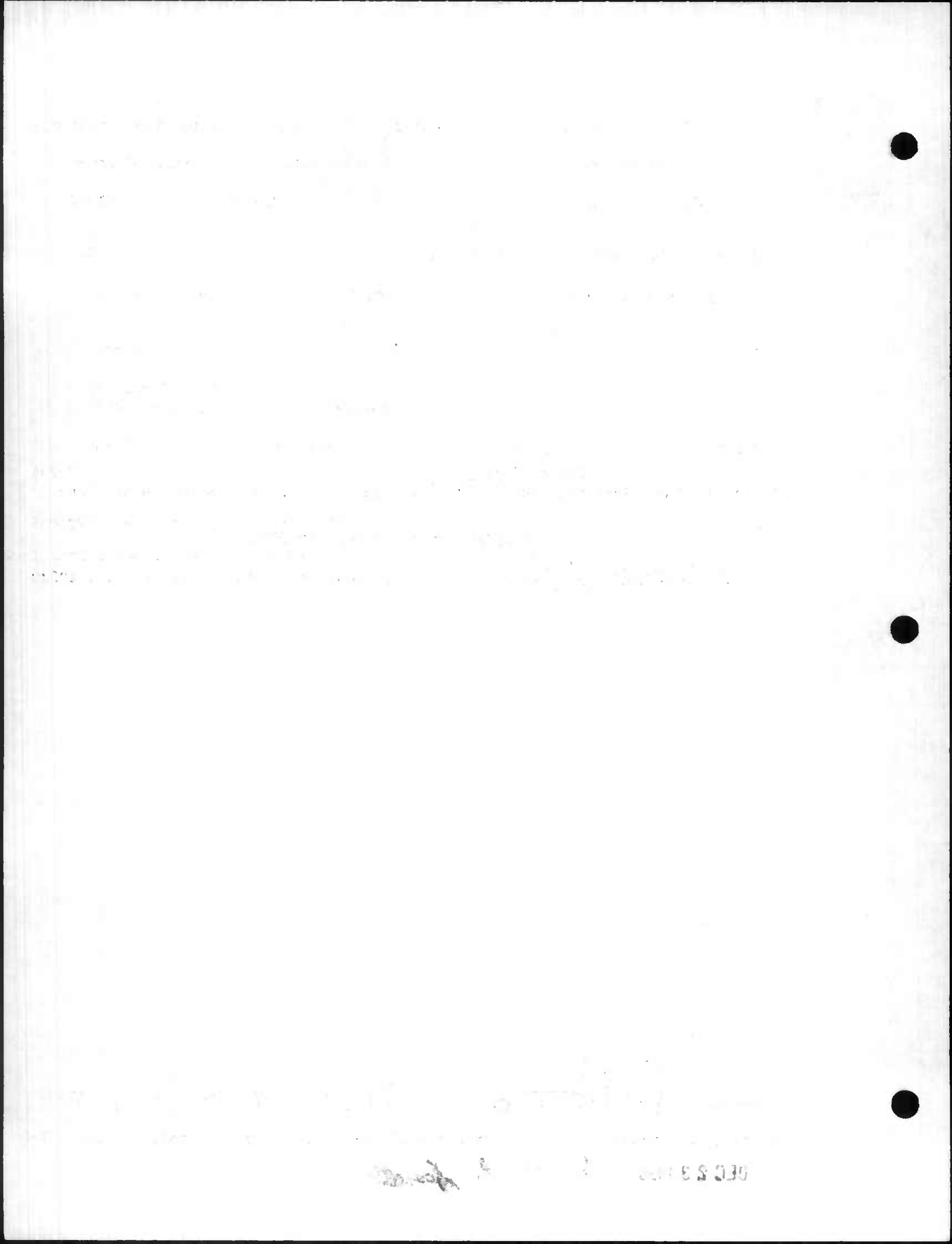
Reg. No.

98 41226

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Thelma Smith Tanner				2. Date of Death Month Day Year December 19, 1998		3. Time of Death 1:30 P.M.		
	4a. Facility Name (If not Institution, give street and number) 6626 St. Barnabas Road				4b. City, Town, or Location of Death Oxon Hill		4c. County of Death Prince Georges		
Funeral Director	5. Social Security Number 578-32-7811	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) May 26, 1917	9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State Maryland		10b. County Prince Georges		10c. City, Town or Location Oxon Hill		10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	10e. Street and Number 6626 St. Barnabas Road				10f. Zip Code 20745		10g. Citizen of What Country? United States		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade		College (1-4 or 5+)		18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Printer's Assistant		18b. Kind of Business/Industry U.S. Government Printing Office		
	17. Father's Name (First, Middle, Last) George Smith				18. Mother's Name (First, Middle, Maiden Surname) Blanche Williams				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Power of Attorney Winston A. Macon (Administrator & Attorney)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12803 Durness Circle, Fort Washington, Maryland 20744				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veterans Cemetery/Cheltenham		20c. Location - City or Town, State Cheltenham, Maryland		20d. Date Dec. 28, 1998		
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Robert G. Mason Funeral Home, Inc. 1661 Good Hope Road, S.E.; Washington, D.C. 20020				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. Respiratory Failure Due to (or as a consequence of): b. Metastatic Cancer of unknown primary Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. hypertension Congestive Heart Failure Venous insufficiency						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicida 4 <input type="checkbox"/> Homicida 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier 		29c. License number D0051194		29d. Date signed (Month, Day, Year) December 21, 1998	
30. Name and address of person who completed use of death (Item 23a) (Type, Print) Emerson L. Coronel, M.D.; 5001 Silver Hill Road, Suite 101; Suitland, Maryland 20746									
31. Date filed (Month, Day, Year) DEC 23 1998				32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 41227

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Wavelon D. Talley

2. Date of Death

Month Day Year  
December 16 1998

3. Time of Death

2:27AM

4a. Facility Name (If not institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

578-38-6010

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

66 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Nov. 9, 1932

9. Birthplace (State or Foreign Country)

Wash., D.C.

Usual Residence of Decedent

10a. State

Maryland Prince George's

10b. County

10c. City, Town or Location

Hyattsville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

7900 Riggs Road

10f. Zip Code

20783

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☐ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
if Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.Specify:  
African  
American15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12th

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Warehouse Manager

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Richard C. Talley

18. Mother's Name (First, Middle, Maiden Surname)

Blanche Jordan

19a. Informant's Name/Relationship (Type, Print)

Helen D. Talley - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7900 Riggs Road, Hyattsville, MD 20783

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Quantico National Cem.

Date

12/21/98

20c. Location - City or Town, State

Triangle, VA

21. Signature of Funeral Service Licensee

John T. Stewart, III

22. Name and Address of Facility

Stewart Funeral Home

4001 Benning Rd., N.E. Wash., D.C. 20019

23a. Pertinent to the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Cardiac Arrest

Due to (or as a consequence of):

b. Atrhythmia

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) LastApproximate  
Interval Between  
Onset and Death

One Hour

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Probable Prostate Cancer

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

David Cromwell, MD

29c. License number

D0 3835

29d. Date signed (Month, Day, Year)

December 21, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David Cromwell, MD - 831 University Blvd. East, Suite 37; Silver Spring, MD 20903

31. Date filed (Month, Day, Year)

DEC 23 1998

32. Registrar's Signature

A. J. J.

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

DEC 23 1953

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41228

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DARRYL F. TELFAIR				2. Date of Death Month Day Year December 22, 1998				3. Time of Death 2:20 AM	
	4a. Facility Name (If not institution, give street and number) Gladys Spellman Nursing Facility				4b. City, Town, or Location of Death Cheverly				4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 577-94-5141		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 34 Yrs.		8. Date of Birth (Month, Day, Year) 7/14/64		9. Birthplace (State or Foreign Country) Wash., D.C.	
	Usual Residence of Decedent									
10a. State D.C.		10b. County N/A		10c. City, Town or Location Washington				10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10e. Street and Number 4612 Quarles St., N.E.				10f. Zip Code 20019				10g. Citizen of What Country? U.S.A.		
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Truck Driver				16b. Kind of Business/Industry Private Industry		
17. Father's Name (First, Middle, Last) Francis Telfair				18. Mother's Name (First, Middle, Maiden Surname) Joan Bond						
19a. Informant's Name/Relationship (Type, Print) Joan Telfair/Mother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as # 10 above						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Harmony Mem. Park		Date 12/29/98		20c. Location - City or Town, State Landover, Md.				
21. Signature of Funeral Service Licensee <i>Larry W. Pratt</i>				22. Name and Address of Facility H.S. Washington & Sons Co., Inc. 4925 Burroughs Ave., N.E., Wash., D.C. 20019						
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <i>Sepsis</i> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death <i>5 days</i>		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>chronic Vegetative state</i>								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Wanda Y. ms.</i>				29c. License number 020077		29d. Date signed (Month, Day, Year) 12/22/98		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Don H. Tobler, MD 7407 Executive place, Leebrook, MD 20706</i>										
31. Date filed (Month, Day, Year) DEC 24 1998		32. Registrar's Signature <i>[Signature]</i>								

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41229

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

EDDIE JOE VANOVER, SR.

2. Date of Death

December 28, 1998

3. Time of Death

9:17 PM

4a. Facility Name (If not institution, give street and number)

Civista Medical Center

4b. City, Town, or Location of Death

La Plata

4c. County of Death

Charles

Funeral  
Director

5. Social Security Number

235-52-7064

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

65

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jan. 9, 1933

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Charles

10c. City, Town or Location

Waldorf

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

305 Rivermont Drive

10f. Zip Code

20602

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Meat Cutter

16b. Kind of Business/Industry

Food Service

17. Father's Name (First, Middle, Last)

Orville Vanover

18. Mother's Name (First, Middle, Maiden Surname)

Dixie Hoosier

19a. Informant's Name/Relationship (Type, Print)

Joan L. Vanover/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

305 Rivermont Drive, Waldorf, Maryland 20602

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Trinity Memorial Gardens

Date

12/31/1998

20c. Location - City or Town, State

Waldorf, Maryland

21. Signature of Funeral Service Licensee

JOHN P. KNISLEY MO1164

22. Name and Address of Facility

Huntt Funeral Home, Inc.  
P. O. Box 156, Waldorf, MD 2060423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Myocardial Infarction

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Hr

b. Atherosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Yr

Sequitally list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Thomas L. Fieldson MD

29c. License number

D01923

29d. Date signed (Month, Day, Year)

Dec 29, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Thomas L. Fieldson, 2068 Crain Highway, Waldorf, MD 20601

State  
Registrar

31. Date filed (Month, Day, Year)

DEC 31 1998

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 41230

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Charles Marvin WAUGH

2. Date of Death  
Month Day Year

December 27 1998

3. Time of Death

1937

4a. Facility Name (If not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

Funeral  
Director

5. Social Security Number

214-09-6483

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

82

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

April 9, 1916

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Funkstown

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5 E. Green Street

10f. Zip Code

21734

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.  
Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,  
Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)  
7

College (1-4 or 5+)  
0

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

owner and operator

16b. Kind of Business/Industry

plumbing & heating

17. Father's Name (First, Middle, Last)

Charles Edwin Waugh

18. Mother's Name (First, Middle, Maiden Surname)

Barbara E. Dixon

19a. Informant's Name/Relationship (Type, Print)

Viola E. Waugh - wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5 E. Green St., Funkstown, Md. 21734

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Funkstown Cemetery

Date

12-30-98

20c. Location - City or Town, State

Funkstown, Maryland

21. Signature of Funeral Service Licensee

*[Signature]*

22. Name and Address of Facility

MINNICH FUNERAL HOME

415 E. Wilson Blvd., Hagerstown, Md. 21740

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.

Immediate Cause (Final  
disease or condition  
resulting in death)

a.

pneumonia

Due to (or as a consequence of):

b.

Renal failure

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Approximate  
Interval Between  
Onset and Death

3 week

3 week

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy  
performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings  
available prior to  
completion of cause  
of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical  
examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other: 4 ☐ Nursing Home

5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury  
(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)

29a. Certifier  
(Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*[Signature]* MD

29c. License number

D 47288

29d. Date signed (Month, Day, Year)

12, 27, 98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S. Iqbal, 12821 Oak Hill Ave., Hagerstown, Md. 21742

31. Date filed (Month, Day, Year)

JAN 04 1999

32. Registrar's Signature

*[Signature]* B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural," or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41231

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Louise Beverly Williams</b>				2. Date of Death Month <b>Dec.</b> Day <b>24</b> , Year <b>1998</b>		3. Time of Death <b>8:34 a.m.</b>	
	4a. Facility Name (If not Institution, give street and number) <b>427 N. Colonial Drive</b>				4b. City, Town, or Location of Death <b>Hagerstown</b>		4c. County of Death <b>Washington</b>	
Funeral Director	5. Social Security Number <b>188-12-4625</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>76</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Jan. 22, 1922</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>Washington</b>		10c. City, Town or Location <b>Hagerstown</b>	
To Be Completed by Funeral Director	Usual Residence of Decedent				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	10e. Street and Number <b>427 N. Colonial Drive</b>				10f. Zip Code <b>21742</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>receptionist</b>		16b. Kind of Business/Industry <b>M. P. Moller Organs</b>			
	17. Father's Name (First, Middle, Last) <b>Homer Judd Cavanaugh</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Nora Virginia Weaver</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Jeffrey L. Williams Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>427 N. Colonial Drive Hagerstown, Maryland 21742</b>			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Rest Haven Cemetery</b>		20c. Location - City or Town, State <b>12/29/98 Hagerstown, Maryland</b>			
	21. Signature of Funeral Service Licensee <i>Gerald N. Minnich</i>				22. Name and Address of Facility <b>Gerald N. Minnich 305 N. Potomac Street Hagerstown, Maryland 21740</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <b>Small Cell Lung Cancer</b> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how Injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
State Registrar	29b. Signature and title of certifier <i>Michael J. McCormack MD</i>				29c. License number <b>041667</b>		29d. Date signed (Month, Day, Year) <b>12-28-98</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Michael J. McCormack 11110 Medical Campus Rd. Suite 130 Hagerstown, MD 21742</b>							
31. Date filed (Month, Day, Year) <b>DEC 28 1998</b>				32. Registrar's Signature <i>B. Sparks</i>				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41232

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Gertrude Ruth WEST

2. Date of Death

Month Day Year  
December 23, 1998

3. Time of Death

9:15 a.m.

4a. Facility Name (If not institution, give street and number)

Reeders Memorial Home

4b. City, Town, or Location of Death

Boonsboro

4c. County of Death

Washington

Funeral  
Director

5. Social Security Number

044-14-4108

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

92

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Feb 10 1906

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

240 S. Potomac Street

10f. Zip Code

21740

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

7

College (1-4 or 5+)

0

18e. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Her own home

17. Father's Name (First, Middle, Last)

Thomas L. McGowan

18. Mother's Name (First, Middle, Maiden Surname)

Ella Pierce

19a. Informant's Name/Relationship (Type, Print)

Glenvol Eichelberger

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

422 Main Street Myersville, Maryland 21773

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Rest Haven Cemetery

Date

12/28/98

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility Minnich Funeral Home

415 E. Wilson Blvd. Hagerstown, Md. 21740

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final  
disease or condition  
resulting in death)a. cerebro-vascular accident  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death

6 days

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. atherosclerosis  
Due to (or as a consequence of):c.   
Due to (or as a consequence of):d.   
Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 8 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of injury  
(Month, Day Year)28b. Time of  
injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D32518

29d. Date signed (Month, Day, Year)

12/23/98

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Dr. Robert Guedenet 100 Geeting Lane, Keedysville, Maryland 21756/301-432-2222

31. Date filed (Month, Day, Year)

DEC 28 1998

32. Registrar's Signature

State  
RegistrarName: Gertrude Ruth West  
Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the Burial-Transit  
permit.

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41233

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Daniel I. Welliver, M.D.

2. Date of Death

Month

Day

Year

December 25, 1998

3. Time of Death

2:20 AM

4a. Facility Name (If not institution, give street and number)

776 Winchester Dr.

4b. City, Town, or Location of Death

Westminster

4c. County of Death

Carroll

Funeral  
Director

5. Social Security Number

215-32-6460

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

70

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

April 20, 1928

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Carroll

10c. City, Town or Location

Westminster

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

776 Winchester Dr.

10f. Zip Code

21157

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates: 1955-5713. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12College (1-4 or 5+)  
5+18e. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Physician

16b. Kind of Business/Industry

Medicine

17. Father's Name (First, Middle, Last)

Reverend Dr. Lester Allen Welliver

18. Mother's Name (First, Middle, Maiden Surname)

Eleanor Yeaworth

19a. Informant's Name/Relationship (Type, Print)

Mary Ada Welliver (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

776 Winchester Dr Westminster MD 21157

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Kniders Cemetery

Date

12/27/98

20c. Location - City or Town, State

Westminster, MD

21. Signature of Funeral Service Licensee

John K. Ayres

22. Name and Address of Facility

Pitts Funeral Home & Chapel, P.A.  
412 Washington Rd Westminster MD 2115723a. Page: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e.

Ventricular Fibrillation

Approximate  
Interval Between  
Onset and Death

10 min

Due to (or as a consequence of):

b.

myocardial infarction

10 min

Due to (or as a consequence of):

c.

Carcinoma of Colon

8 mos.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Kuan Peng

29c. License number

D38915

29d. Date signed (Month, Day, Year)

12/28/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FRT 101 29 S Stoner Ave Westminster 21157

State  
Registrar

31. Date filed (Month, Day, Year)

DEC 28 1998

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
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within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41234

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Evelyn Lillian Williams				2. Date of Death Month Day Year December 14, 1998		3. Time of Death 9:13 PM		
	4a. Facility Name (If not institution, give street and number) 46354 Columbus Drive #1103				4b. City, Town, or Location of Death Lexington Park		4c. County of Death St. Mary's		
Funeral Director	5. Social Security Number 480-24-2454		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 74 Yrs.		8. Date of Birth (Month, Day, Year) March 30, 1924		
	9. Birthplace (State or Foreign Country) Iowa		10a. State Maryland		10b. County St. Mary's		10c. City, Town or Location Lexington Park		
Usual Residence of Decedent		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 46354 Columbus Drive #1103		10f. Zip Code 20653		10g. Citizen of What Country? U.S.A.	
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 3 Years		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary		16b. Kind of Business/Industry U.S. Government					
17. Father's Name (First, Middle, Last) George Williams				18. Mother's Name (First, Middle, Maiden Surname) Mary Volkmann					
19a. Informant's Name/Relationship (Type, Print) Paul LaPorte/ Executor				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1549 Mapleton Drive, Dallas, Texas 75228					
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		Date 12/18/98		20c. Location - City or Town, State Alexandria, Virginia			
21. Signature of Funeral Service Licensee <i>Michael Howard Gordon</i>				22. Name and Address of Facility Matteringley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, MD 20650					
23a. Part I. Enter the disease or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Atherosclerotic cardiovascular disease</i> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		26. Place of Death (Check only one) Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) —		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred —	
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) —		28f. Location (Street and Number or Rural Route Number, City or Town, State) —					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>William Boyd, II</i>		29c. License number D14285		29d. Date signed (Month, Day, Year) 12-17-98			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) William Boyd, II, MD Leonardtown, Maryland 20650									
31. Date filed (Month, Day, Year) DEC 21 1998		32. Registrar's Signature <i>Genevieve B. Sparks</i>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

DB  
10

The first part of the report deals with the general situation of the country. It is a very interesting and informative study of the country's development. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is easy to read. It is a valuable contribution to the study of the country's development.

The second part of the report deals with the economic situation of the country. It is a very interesting and informative study of the country's economic development. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is easy to read. It is a valuable contribution to the study of the country's economic development.

The third part of the report deals with the social situation of the country. It is a very interesting and informative study of the country's social development. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is easy to read. It is a valuable contribution to the study of the country's social development.

The fourth part of the report deals with the political situation of the country. It is a very interesting and informative study of the country's political development. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is easy to read. It is a valuable contribution to the study of the country's political development.

The fifth part of the report deals with the cultural situation of the country. It is a very interesting and informative study of the country's cultural development. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is easy to read. It is a valuable contribution to the study of the country's cultural development.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41235

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Rosa Etta Walls

2. Date of Death

December 19, 1998 3:03pm.

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Doctors Community Hospital

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince George's Co.

5. Social Security Number

220-48-6347

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

99

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 7, 1899

9. Birthplace (State or Foreign Country)

Clinton MD

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Clinton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11000 Brandywine Road

10f. Zip Code

20735

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

7th

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Josiah Proctor

18. Mother's Name (First, Middle, Maiden Surname)

Ida Brown

19a. Informant's Name/Relationship (Type, Print)

Andrew Walls (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11000 Brandywine Road Clinton, Maryland 20735

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Resurrection Cemetery

Data

Dec. 23,

1998

20c. Location - City or Town, State

Clinton, Maryland

21. Signature of Funeral Service Licensee

▶ 5th E. Sitt

22. Name and Address of Facility

Lee Funeral Home, Inc.

6633 Old Alexandria Ferry Rd Clinton, MD 20735

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Cardiomyopathy

Due to (or as a consequence of):

b. arteriosclerosis

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

20 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Sepsis  
dehydration

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

▶ R. Dakheel M.D.

29c. License number

D 26492

29d. Date signed (Month, Day, Year)

12.19.98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rod Dakheel, M.D. 4000 Mitchellville Rd, Bowie, MD 20716

31. Date filed (Month, Day, Year)

DEC 22 1998

32. Registrar's Signature

▶ Geneva S. Sparks

State  
RegistrarRosa E Walls  
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 41236

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Helen B. Weadon						2. Date of Death Month Day Year December 19, 1998		3. Time of Death 1:20 am	
	4a. Facility Name (If not Institution, give street and number) 8730 D Street						4b. City, Town, or Location of Death Chesapeake Beach		4c. County of Death Calvert	
Funeral Director	5. Social Security Number 225 32 9145		8. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 67 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	6. Date of Birth (Month, Day, Year) Apr. 11, 1931		9. Birthplace (State or Foreign Country) VA							
To Be Completed by Funeral Director	Usual Residence of Decedent									
	10a. State MD		10b. County Calvert		10c. City, Town or Location Chesapeake Beach				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 8730 D Street				10f. Zip Code 20732		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) secretary			16b. Kind of Business/Industry Education		
	17. Father's Name (First, Middle, Last) Henry Breeden					18. Mother's Name (First, Middle, Maiden Surname) Mary Powell				
	19a. Informant's Name/Relationship (Type, Print) Preston R. Weadon/spouse					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PO Box 344, Chesapeake Beach, MD 20732				
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		Date 12-20-98		20c. Location - City or Town, State Alexandria, VA		
	21. Signature of Funeral Service Licensee 					22. Name and Address of Facility Rausch Funeral Home, Owings, MD 20736				
	Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. LUNG (SMALL CELL) CANCER WITH BRAIN METASTASIS. Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):								
Approximate Interval Between Onset and Death several months										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier 					29c. License number D - 025519		29d. Date signed (Month, Day, Year) 12-19-98			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Atul Shah, M.D., Prince Frederick, MD 20678										
State Registrar	31. Date filed (Month, Day, Year) DEC 21 1998		32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





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State of Maryland / Department of Health and Mental Hygiene 98 41237

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Maude Catherine Windsor</b>				2. Date of Death Month Day Year <b>Dec. 17, 1998</b>		3. Time of Death <b>6:51 P.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>9130 Southern Maryland Blvd.</b>				4b. City, Town, or Location of Death <b>Owings</b>		4c. County of Death <b>Calvert</b>	
Funeral Director	5. Social Security Number <b>217-66-0122</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>75</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>June 11, 1923</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>Calvert</b>		10c. City, Town or Location <b>Owings</b>	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number <b>9130 Southern Maryland Blvd.</b>		10f. Zip Code <b>20736</b>	
	10g. Citizen of What Country? <b>United States</b>				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6th Grade</b> College (1-4 or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Housewife</b>				16b. Kind of Business/Industry <b>Home</b>		17. Father's Name (First, Middle, Last) <b>John Francis Thomas</b>	
To Be Completed by Physician/Medical Examiner	18. Mother's Name (First, Middle, Maiden Surname) <b>Martha Ann F. Beatly</b>				19a. Informant's Name/Relationship (Type, Print) <b>V. Elvis Windsor (son)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9130 Southern Maryland Blvd., Owings, MD 20736</b>	
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) <b>Entombment</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Resurrection Cemetery</b>		20c. Location - City or Town, State <b>Clinton, Maryland</b>		21. Signature of Funeral Service Licensee <b>Lee Funeral Home, Calvert, P.A.</b>	
To Be Completed by Physician/Medical Examiner	22. Name and Address of Facility <b>8125 Southern MD. Blvd., Owings, MD 20736</b>				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Hepatorenal failure</b> Due to (or as a consequence of): <b>Hepatitis</b> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>Hepatitis</b> Due to (or as a consequence of):		Approximate Interval Between Onset and Death	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <b>Catherine Brophy MD</b>		29c. License number <b>045235</b>	
To Be Completed by Physician/Medical Examiner	29d. Data signed (Month, Day, Year) <b>December 18, 1998</b>				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Catherine Brophy, MD, 10845 Town Center Blvd., Dunkirk, Maryland 20754</b>		31. Date filed (Month, Day, Year) <b>DEC 21 1998</b>	
	32. Registrar's Signature <b>[Signature]</b>				33. Registrar's Title <b>[Signature]</b>		34. Registrar's Name <b>[Signature]</b>	

Baltimore, Maryland 21215-0020

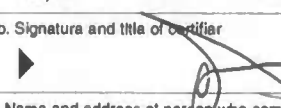
Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 41238  
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>CLIFFORD HENRY WALLACE, SR.</b>				2. Date of Death Month Day Year <b>DECEMBER 19 1998</b>		3. Time of Death <b>3:15AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>204 WEST LAKE BOULEVARD</b>				4b. City, Town, or Location of Death <b>PRINCE FREDERICK</b>		4c. County of Death <b>CALVERT</b>	
Funeral Director	5. Social Security Number <b>074-16-4043</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>75</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>MAY 5, 1923</b>	9. Birthplace (State or Foreign Country) <b>NEW YORK</b>
	Usual Residence of Decedent				10a. State <b>MARYLAND</b>		10b. County <b>CALVERT</b>	
To Be Completed by Funeral Director	10c. City, Town or Location <b>PRINCE FREDERICK</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>204 WEST LAKE BOULEVARD</b>	
	10f. Zip Code <b>20678</b>				10g. Citizen of What Country? <b>U. S. A.</b>		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>W.W.II</b>				13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>TRUCK DRIVER</b>		16b. Kind of Business/Industry <b>TRUCKING</b>	
	17. Father's Name (First, Middle, Last) <b>DEWEY WALLACE</b>				18. Mother's Name (First, Middle, Maiden Summa) <b>MYRTLE DAVENPORT</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>MAMIE V. WALLACE/WIFE</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>204 WEST LAKE BLVD. PRINCE FREDERICK, MD 20678</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MD VETERANS CEMETERY</b>		20c. Location - City or Town, State <b>DEC. 22, 1998 CHELTENHAM, MARYLAND</b>	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>LEE FUNERAL HOME CALVERT, P.A. 8125 SOUTHERN MD BLVD. OWINGS, MARYLAND 20736</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. PANCREATIC CARCINOMA</b> Due to (or as a consequence of):  <b>b.</b> Due to (or as a consequence of):  <b>c.</b> Due to (or as a consequence of):  <b>d.</b>				Approximate Interval Between Onset and Death <b>1 yr</b>			
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No				25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				
28a. Date of Injury (Month, Day, Year)				28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and Title of Certifier 		29c. License number <b>D29657</b>		
29d. Date signed (Month, Day, Year) <b>12/21/98</b>				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. Charles Judge, PRINCE FRED. MD 20678</b>				
31. Date filed (Month, Day, Year) <b>DEC 21 1998</b>				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

January 1944

1944-1945

1945-1946

1946-1947

1947-1948

1948

1949

1950-1951

1951-1952

1952-1953

1953-1954

1954-1955

1955-1956

1956-1957

1957-1958

1958-1959

1959-1960

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41239

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mattie L. Wilson						2. Date of Death Month Day Year December 20 1998		3. Time of Death 3:00AM		
	4a. Facility Name (If not Institution, give street and number) Randolph Hill Nursing Home						4b. City, Town, or Location of Death Wheaton		4c. County of Death Montgomery		
Funeral Director	5. Social Security Number 579-84-6402		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 90 Yrs.		8. Date of Birth (Month, Day, Year) Oct. 5 1908		9. Birthplace (State or Foreign Country) South Carolina		
	Usual Residence of Decedent										
10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Silver Spring				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
10e. Street and Number 13940 Alderton Road				10f. Zip Code 20906		10g. Citizen of What Country? United States					
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elevator Operator			16b. Kind of Business/Industry Government				
17. Father's Name (First, Middle, Last) Joseph Lowery						18. Mother's Name (First, Middle, Maiden Surname) Mattie Austen					
19a. Informant's Name/Relationship (Type, Print) Marie A. Tapscott - Daughter						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13940 Alderton Rd., Silver Spring, MD 20906					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Washington National Cem.		Date 12/28/98		20c. Location - City or Town, State Suitland, MD			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>acute myocardial infarction</u> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death <u>Hours</u>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury of Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
				28d. Describe how injury occurred							
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							
				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier 						29c. License number DO 9834		29d. Date signed (Month, Day, Year) December 22, 1998			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BARRY ROSENBAUM 3720 FARRAGUT AVE KENSINGTON, MD 20895											
31. Date filed (Month, Day, Year) DEC 24 1998				32. Registrar's Signature 							

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

3

*Handwritten signature*

DEC 5 4 30



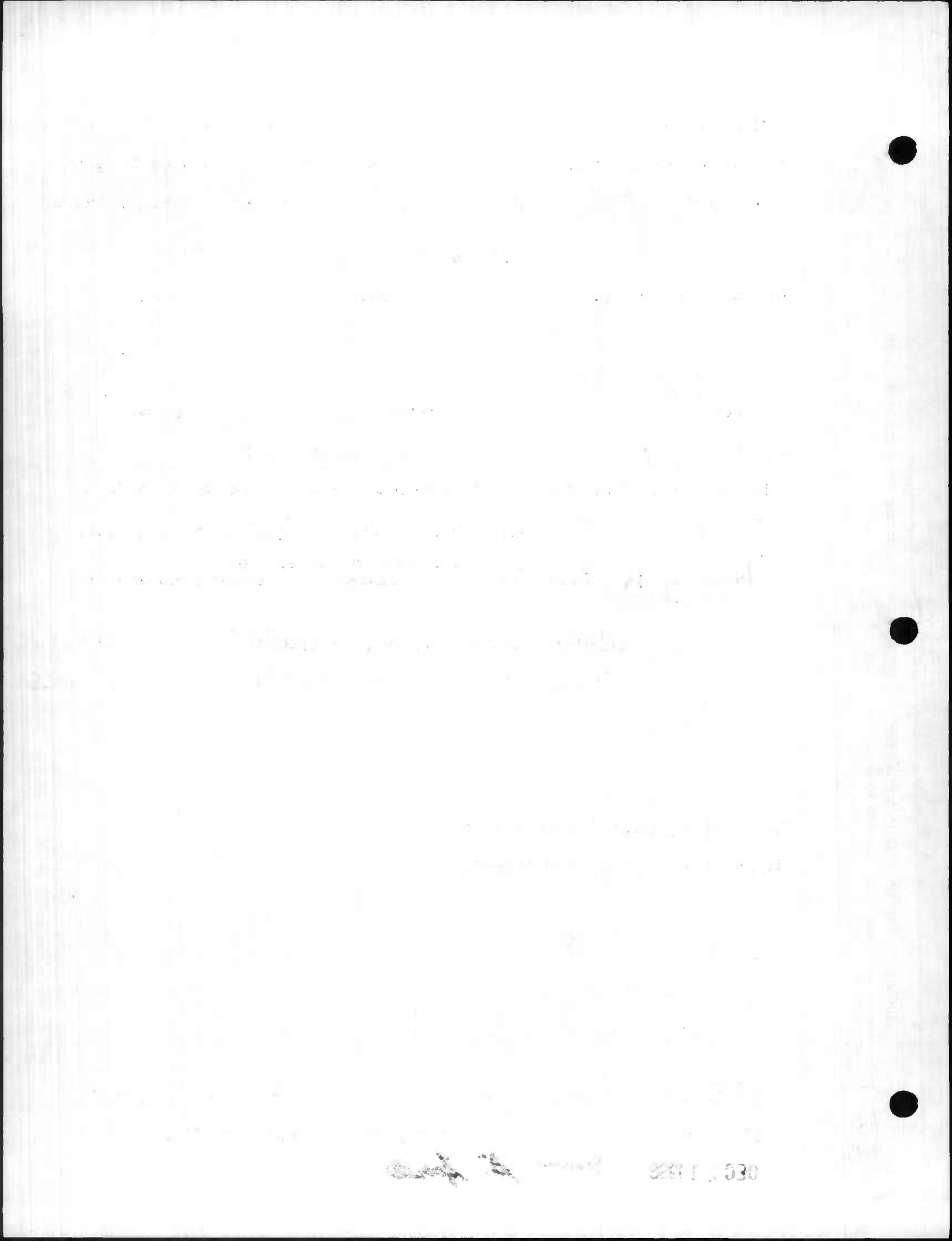
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 41240

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JAMES WASHINGTON</b>				2. Date of Death Month <b>12</b> Day <b>16</b> Year <b>98</b>		3. Time of Death <b>3:45 am</b>	
	4a. Facility Name (If not institution, give street and number) <b>Prince George's Hospital</b>				4b. City, Town, or Location of Death <b>Cheverly</b>		4c. County of Death <b>Prince George's</b>	
Funeral Director	5. Social Security Number <b>579-05-9294</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>88</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>November 4, 1910</b>	
	9. Birthplace (State or Foreign Country) <b>Washington, D.C.</b>		10a. State <b>Washington, D.C.</b>		10b. County		10c. City, Town or Location <b>Washington, D.C.</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>1050 42nd Street N.E.</b>		10f. Zip Code <b>20017</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Laborer</b>		16b. Kind of Business/Industry <b>Private</b>		17. Father's Name (First, Middle, Last) <b>Marcel Washington</b>	
	18. Mother's Name (First, Middle, Maiden Surname) <b>Queen Mary Hayden</b>		19a. Informant's Name/Relationship (Type, Print) <b>Kolleen Brimberry/Daughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>511 Schenectady Street, Schenectady, N.Y. 12307</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	
Physician /Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mt. Olivet Cemetery</b>		20c. Date <b>12/22 1998</b>		20d. Location - City or Town, State <b>Washington, D.C.</b>		21. Signature of Funeral Service Licensee <b>Nancy A. Perentis</b>	
	22. Name and Address of Facility <b>J.B. Jenkins Funeral Home 7474 Landover Road, Landover, Maryland 20785</b>		23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>a. CARDIORESPIRATORY ARREST</b> Due to (or as a consequence of): <b>b. PULMONARY EMBOLISM</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		23c. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	23d. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ESOPHAGEAL CANCER</b> <b>ATRIAL ARRHYTHMIAS</b>		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
	29b. Signature and title of certifier <b>Linda Green</b>		29c. License number <b>D21428</b>		29d. Date signed (Month, Day, Year) <b>12/17/98</b>		30. Name and address of person who completed causa of death (Item 23e) (Type, Print) <b>Linda Green, M.D., 3001 Hospital Drive, Cheverly, Maryland 20785</b>	
State Registrar	31. Date filed (Month, Day, Year) <b>DEC 21 1998</b>		32. Registrar's Signature <b>[Signature]</b>		33. Registrar's Title <b>[Signature]</b>		34. Registrar's Office <b>[Signature]</b>	



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41241

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

DAFNEY WRIGHT

2. Date of Death  
Month Day Year  
Dec 15 1998

3. Time of Death  
0215

4a. Facility Name (If not institution, give street and number)

Mariner Health Care, 14200 Laurel Park Dr. Laurel MD

4b. City, Town, or Location of Death

4c. County of Death

Prince George

Funeral  
Director

5. Social Security Number

577 66 6387

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

March 11 1922

9. Birthplace (State or Foreign Country)

Kingston Jamaica

Usual Residence of Decedent

10a. State

D.C.

10b. County

10c. City, Town or Location

Washington

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

414 19th Street, N.E.

10f. Zip Code

20002

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12th

College (1-4 or 5+)

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Self Employed

16b. Kind of Business/Industry

Domestic

17. Father's Name (First, Middle, Last)

Samuel Elliott

18. Mother's Name (First, Middle, Maiden Surname)

Susan Hendrick

19a. Informant's Name/Relationship (Type, Print)

Uli Yahu, son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10023 Belle River Blvd, Jacksonville FA, 32256

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Forest Hills Mem

Date

12/23/98 Clinton MD 20735

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Robert A. Smith

22. Name and Address of Facility

HALL BROTHERS FUNERAL HOME  
621 Florida Ave., NW, Wash., D.C. 20001

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Due to (or as a consequence of):

Hypertension

Approximate Interval Between Onset and Death

years

b.

Due to (or as a consequence of):

Abdominal malignancy months

c.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CVA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

28. Place of Death (Check only one)

4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D 28998

29d. Date signed (Month, Day, Year)

Dec 18 1998

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

PRITAM S.S.A.M. MD  
9101 Cherry LN # 211 Laurel MD 20708

31. Date filed (Month, Day, Year)

DEC 21 1998

32. Registrar's Signature

[Signature]

State Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

(2)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41242

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Clarence Branham</b>				2. Date of Death Month Day Year <b>DEC. 26, 1998</b>		3. Time of Death <b>2:15 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Joseph Richey Hospice</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>214-38-1295</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>58</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>MAR 5, 1940</b>	
	10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>1812 W. Pratt St.</b>				10f. Zip Code <b>21223</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>Unknown</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Carpenter</b>		16b. Kind of Business/Industry <b>Carpentry</b>		
17. Father's Name (First, Middle, Last) <b>Unknown</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Odell Brown</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Terry W. Branham - son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>210 S. Harmison St., Balto., Md. 21223</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Baltimore Washington CR.</b>		20c. Location - City or Town, State <b>Laurel, Md.</b>		
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <b>Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc. 7250 Washington Blvd., Elkridge, Md. 21075</b>				
23a. Enter all causes or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>c. carcinoma of lung</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d.</b>				Approximate Interval Between Onset and Death				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>chronic obstructive lung disease</b>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Hospice				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and Title of certifier <b>John N. Payne</b>		29c. License number <b>013012</b>		29d. Date signed (Month, Day, Year) <b>27 DEC 98</b>
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>John Payne 4543 N. Charles St 21204</b>				31. Date filed (Month, Day, Year) <b>JAN 12 1999</b>				
32. Registrar's Signature <i>[Signature]</i>				33. State Registrar <b>State Registrar</b>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41243

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ROY F BAXTER</b>				2. Date of Death Month <b>December</b> Day <b>20</b> Year <b>1998</b>		3. Time of Death <b>2345</b>		
	4a. Facility Name (If not institution, give street and number) <b>7620 OLD GEORGETOWN ROAD</b>				4b. City, Town, or Location of Death <b>BETHESDA</b>		4c. County of Death <b>MONTGOMERY</b>		
Funeral Director	5. Social Security Number <b>218-24-0918</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>68</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Oct. 8, 1930</b>		
	9. Birthplace (State or Foreign Country) <b>Virginia</b>		10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Bethesda</b>		
Usual Residence of Decedent									
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
10a. Street and Number <b>7620 Old Georgetown Road</b>				10f. Zip Code <b>20814</b>		10g. Citizen of What Country? <b>United States</b>			
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Delivery</b>		16b. Kind of Business/Industry <b>Payroll</b>			
17. Father's Name (First, Middle, Last) <b>William Baxter</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Nellie Baxter</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Evelyn Jean Mitchell/Niece</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8365 Gatewood Drive, Jessup, Maryland 20794</b>					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Montgomery Crematorium, Inc.</b>		20c. Location - City or Town, State <b>Bethesda, Maryland</b>			
21. Signature of Funeral Service Licensee <b>[Signature]</b> M00198				22. Name and Address of Facility <b>Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc.</b> <b>7557 Wisconsin Avenue Bethesda, Maryland 20814-3501</b>					
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
Immediate Cause (Final disease or condition resulting in death)									
a. <b>ACUTE MYOCARDIAL INFARCTION</b>									
Due to (or as a consequence of):									
b. <b>ARTEROSCLEROTIC CARDIOVASCULAR DISEASE</b>									
Due to (or as a consequence of):									
c. <b>DIABETES MELLITUS</b>									
Due to (or as a consequence of):									
d.									
23a. Part 2. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
Approximate Interval Between Onset and Death									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown									
24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29c. License number <b>015236</b>					
29b. Signature and title of certifier <b>[Signature] M.D. (OMG)</b>				29d. Date signed (Month, Day, Year) <b>December 21, 1998</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>CARL L. MARGOLIS, M.D. 11125 ROCKVILLE PIKE, ROCKVILLE MD 20852</b>									
31. Date filed (Month, Day, Year) <b>JAN 12 1999</b>				32. Registrar's Signature <b>[Signature] B. Sparks</b>					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

LLOYD ELMER GODDARD

2. Date of Death  
Month Day Year

DECEMBER 31 1998

3. Time of Death

11:30 a.m.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

GOOD SAMARITAN HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

235-28-6902

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

74

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

April 27, 1924

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Dundalk

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1804 Kinship Road

10f. Zip Code

21222

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

8 Years

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Steelworker

16b. Kind of Business/Industry

Steel Industry

17. Father's Name (First, Middle, Last)

Donnie Aaron Goddard

18. Mother's Name (First, Middle, Maiden Surname)

Goldie Elsie Martin

19a. Informant's Name/Relationship (Type, Print)

Pauline C. Goddard/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1804 Kinship Road Dundalk, Maryland 21222

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Oak Lawn Cemetery

Date

Jan. 2, 1999

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Duda-Ruck Funeral Home of Dundalk, Inc.  
7922 Wise Ave. Dundalk, MD 2122223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. SEPSIS  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death

13 DAYS

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Lastb. STAPHYLOCOCCUS BACTEREMIA  
Due to (or as a consequence of):

13 DAYS

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC OBSTRUCTIVE PULMONARY  
DISEASE

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

P12126

29d. Date signed (Month, Day, Year)

DECEMBER 31 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WALID ABOUJAOUDE M.D

6920 MONACHIE ROAD # 705  
BALTIMORE M.D 21239

31. Date filed (Month, Day, Year)

JAN 6 1999

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 41245

## Certificate of Death

Reg. No.

Item: 4a per M.D.G-767 1/12/99 reh

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Ruth R. Hall

2. Date of Death

December 15 1998

3. Time of Death

10:50 AM

4a. Facility Name (If not institution, give street and number)

GRANDA NURSING HOME INC.

LIBERTY MEDICAL CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

216-24-2795

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

95

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

JUNE 12, 1903

9. Birthplace (State or Foreign Country)

ANNE ARUNDEL CO.

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3508 SPRINGDALE AVE.

10f. Zip Code

21216

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: AFRO.AMERICAN

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

DOMESTIC WORKER

16b. Kind of Business/Industry

HOUSEHOLD

17. Father's Name (First, Middle, Last)

ROBERT RICHARDS

18. Mother's Name (First, Middle, Maiden Surname)

ANNIE E. RICHARDS

19a. Informant's Name/Relationship (Type, Print)

SELMA BROGDEN DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3508 SPRINGDALE AVE, BALTIMORE, MARYLAND 21216

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MT. ZION CEMETERY

Date

12/21/98 PASADENA, MD.

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

LLOYD M. ESTEP

22. Name and Address of Facility

ESTEP BROTHERS FUNERAL SER, P.A.  
1300 EUTAW PLACE, BALTIMORE, MARYLAND 21217

23a. Part II. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Uro sepsis

Due to (or as a consequence of):

Unknown

b. Dehydration

Due to (or as a consequence of):

Unknown

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Cerebrovascular Accident

Due to (or as a consequence of):

Unknown

d. Chronic obstructive pulmonary disease

Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

Dysphagia

Peripheral vascular disease

Dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending Investigation2 ☐ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

L M D

29c. License number

D33583

29d. Date signed (Month, Day, Year)

December 15, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hafez Zrebeet, M.D. LMC

2600 Liberty Heights Ave  
Baltimore, Md 21215

31. Date filed (Month, Day, Year)

JAN 12 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Items: 15, 16a, b, 19a, b per F.H.G-767 1/12/99 r Certificate of Death

Reg. No.

98 41246

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last) <i>Sonia Krolicka</i>				2. Date of Death Month <i>12</i> Day <i>27</i> Year <i>98</i>				3. Time of Death <i>5 PM</i>	
4a. Facility Name (If not institution, give street and number) <i>Liberty Medical Center</i>				4b. City, Town, or Location of Death <i>Baltimore</i>				4c. County of Death <i>Baltimore City</i>	
5. Social Security Number <i>212-03-3732</i>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <i>87</i> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
8. Date of Birth (Month, Day, Year) <i>April 15 1911</i>				9. Birthplace (State or Foreign Country) <i>Maryland</i>					
Usual Residence of Decedent									
10a. State <i>Maryland</i>		10b. County <i>N/A</i>		10c. City, Town or Location <i>Baltimore</i>				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10e. Street and Number <i>2219 Orem Avenue</i>				10f. Zip Code <i>21217</i>				10g. Citizen of What Country? <i>USA</i>	
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <i>White</i>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>4</i>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Teacher SEAMSTRESS</i>				16b. Kind of Business/Industry <i>CLOTHING Baltimore City Schools</i>	
17. Father's Name (First, Middle, Last) <i>Joseph Krolicka</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Zuzanna Waluszka</i>					
19a. Informant's Name/Relationship (Type, Print) <i>DAVID J. WEBER/ REPRESENTATIVE</i> <i>Diane Williams/Neighbor</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>401 S. CHESTER ST. BALTIMORE, MD. 21231</i> <i>511 Belmont Ave. Baltimore Maryland 21207</i>					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Holy Rosary Cemetery</i>				20c. Location - City or Town, State <i>1/7/99 Baltimore</i>	
21. Signature of Funeral Service Licensee <i>David J. Weber</i>				22. Name and Address of Facility <i>David J. Weber Funeral Homes, P.A.</i> <i>401 South Chester St. Baltimore, Maryland 21231</i>					
23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <i>a. Congestive Heart Failure</i> Due to (or as a consequence of):  <i>b.</i> Due to (or as a consequence of):  <i>c.</i> Due to (or as a consequence of):  <i>d.</i>				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				Approximate Interval Between Onset and Death	
23a. Pert 2. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  <i>Pulmonary Embolism</i> <i>Senile Dementia</i>				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>Donald Bauer</i>				29c. License number <i>D36353</i>	
29d. Date signed (Month, Day, Year) <i>12/28/98</i>				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Don Bauer 2411 W. Belvedere Ave Suite 302 Baltimore</i>					
31. Date filed (Month, Day, Year) <i>JAN 12 1999</i>				32. Registrar's Signature <i>Bruce B. Sparks</i>					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41247

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Christine M. Peterson</b>				2. Date of Death Month <b>December</b> Day <b>23</b> , 1998 Year		3. Time of Death <b>1 P.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>1902 Cedar Road</b>				4b. City, Town, or Location of Death <b>Pasadena</b>		4c. County of Death <b>Anne Arundel</b>	
Funeral Director	5. Social Security Number <b>218-32-3332</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>101</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>July 9, 1897</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Pasadena</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>1902 Cedar Road</b>		10f. Zip Code <b>21122</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>3</b> College (1-4 or 5+) <b>N/A</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Owner</b>		16b. Kind of Business/Industry <b>Lumber Co.</b>			
	17. Father's Name (First, Middle, Last) <b>Sabastian L. Schnader</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Elisabetha Rau</b>			
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Robert G. Peterson Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1902 Cedar Road Pasadena, Maryland 21122</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Most Holy Redeemer</b>		20c. Location - City or Town, State <b>Baltimore, Maryland</b>		20d. Date <b>Dec. 28, 1998</b>	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <i>Valerie L. Polyniak</i>				22. Name and Address of Facility <b>McCully-Polyniak Funeral Home</b> <b>3204 Mountain Road Pasadena, Maryland 21122</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. <i>Atherosclerotic Cardiovascular Disease</i></b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. <i>Dehydration</i></b> Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>Christopher DeBarja</i>		29c. License number <b>042820</b>	
	29d. Date signed (Month, Day, Year) <b>12/24/98</b>		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Christopher DeBarja 3708 Mountain Rd. Pasadena Md. 21122</b>					
State Registrar	31. Date filed (Month, Day, Year) <b>JAN 12 1999</b>				32. Registrar's Signature <i>B. Sparks</i>			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 98 41248

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Joseph Dennis Allen</b>				2. Date of Death Month <b>December</b> Day <b>29</b> , Year <b>1998</b>		3. Time of Death <b>7:00 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Holy Cross Rehabilitation and Nursing Center</b>				4b. City, Town, or Location of Death <b>Burtonsville</b>		4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>578-38-4990</b>		6. Sex <b>1</b> M <b>2</b> F		7. Age (in yrs. last birthday) <b>86</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>April 2, 1912</b>	
	9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>		10a. State <b>MD</b>		10b. County <b>Prince Georges</b>		10c. City, Town or Location <b>University Park</b>	
10d. Inside City Limits <b>1</b> Yes <b>2</b> No		10e. Street and Number <b>4203-A Woodberry Street</b>		10f. Zip Code <b>20782</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <b>1</b> Never Married <b>2</b> Married <b>3</b> Widowed <b>4</b> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <b>1</b> Yes <b>2</b> No If Yes, Give Year or Dates: <b>1950-72</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> Yes <b>2</b> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DD NDT use retired) <b>Accountant</b>		16b. Kind of Business/Industry <b>Federal Government</b>				
17. Father's Name (First, Middle, Last) <b>Bernard James Allen</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Elizabeth O'Day</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Geraldine M. Woodworth (niece)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4203-A Woodberry Street, University Park, MD 20782</b>				
20a. Method of Disposition <b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State <b>4</b> Donation <b>5</b> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gate of Heaven Cemetery</b>		Date <b>12/31/98</b>		20c. Location - City or Town, State <b>Silver Spring, MD</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Dementia</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. {</b> <b>c. {</b> <b>d. {</b>								
Approximate Interval Between Onset and Death <b>5 years.</b>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown		
						24e. Was an autopsy performed? <b>1</b> Yes <b>2</b> No		
						24b. Were autopsy findings available prior to completion of cause of death? <b>1</b> Yes <b>2</b> No		
25. Was case referred to medical examiner? <b>1</b> Yes <b>2</b> No		Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA		26. Place of Death (Check only one) Other: <b>4</b> Nursing Home <b>5</b> Residence <b>8</b> Other (Specify)				
27. Manner of Death <b>1</b> Natural <b>2</b> Accident <b>3</b> Suicide <b>4</b> Homicide <b>5</b> Pending investigation <b>6</b> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <b>1</b> Yes <b>2</b> No		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <b>1</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier MD				29c. License number <b>D43237</b>		29d. Date signed (Month, Day, Year) <b>12-30-98</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Paul Armstrongs MD 14201 Laurel PK Dr #102 Laurel MD 20707</b>								
31. Date filed (Month, Day, Year) <b>DEC 31 1998</b>				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

38 41249

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Lucille Smith Anderson

2. Date of Death

December 23, 1998

3. Time of Death

9:07 pm

4a. Facility Name (If not institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

577-50-5469

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sept. 14, 1917

9. Birthplace (State or Foreign Country)

Indiana

Usual Residence of Decedent

10a. State

Md

10b. County

Howard

10c. City, Town or Location

Ellicott City

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3417 FONT HILLS DR.

10f. Zip Code

21042

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Accountant

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

Arthur Smith

18. Mother's Name (First, Middle, Maiden Surname)

Catherine Burden

19a. Informant's Name/Relationship (Type, Print)

Alan A. Anderson III (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1915 Bronze Gate Blvd. Silver Spring, MD 20904

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

12-29-98

20c. Location - City or Town, State

Silver Spring, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Hines-Rinaldi 11800 New

Hampshire Ave. Silver Spring, Md 20904

Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Acute Respiratory Failure

Due to (or as a consequence of):

b. Metastatic Cancer of Breast - Pulm Abscess

Due to (or as a consequence of):

c. Chronic Obstructive Pulm. Disease

Due to (or as a consequence of):

d. Congestive Heart Failure

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus

Hypertension

Malnutrition

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy

performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings

available prior to

completion of cause

of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical

examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

Investigation

8 ☐ Could not be

determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)

29a. Certifier

(Check only one)

1 ☒ Certifying Physician:

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner:

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Samuel L. Deshay M.D.

29c. License number

D19935

29d. Date signed (Month, Day, Year)

12/24/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SAMUEL L. DESHAY, M.D., 7610 CARROLL AVE, TAKOMA PARK, MD 20912

31. Date filed (Month, Day, Year)

DEC 29 1998

32. Registrar's Signature

Beverly G. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41250

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>JULIA AUERBACH</b>						2. Date of Death Month Day Year <b>DECEMBER 30, 1998</b>		3. Time of Death <b>1:00 AM</b>	
4a. Facility Name (If not institution, give street and number) <b>HEBREW HOME OF GREATER WASHINGTON</b>						4b. City, Town, or Location of Death <b>ROCKVILLE</b>		4c. County of Death <b>MONTGOMERY</b>	
5. Social Security Number <b>052.05.0532</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>85</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>12.09.1913</b>		9. Birthplace (State or Foreign Country) <b>MASS.</b>	
Usual Residence of Decedent									
10e. State <b>MD</b>		10b. County <b>MONTGOMERY</b>		10c. City, Town or Location <b>ROCKVILLE</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>6121 MONTROSE ROAD</b>				10f. Zip Code <b>20852</b>		10g. Citizen of What Country? <b>USA</b>			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)				18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOMEMAKER</b>			16b. Kind of Business/Industry <b>OWN HOME</b>		
17. Father's Name (First, Middle, Last) <b>ISAAC RIVKIN</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>MARY CUBEL</b>			
19a. Informant's Name/Relationship (Type, Print) <b>MARSHA FABEL/DAUGHTER</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>14120 FLINT ROCK ROAD, ROCKVILLE, MARYLAND 20853</b>					
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>STAR OF DAVID MEMORIAL G.I./5/99 N. LAUDERDALE, FLORIDA</b>		Date		20c. Location - City or Town, State	
21. Sign  Serv. nsee				22. Name and Address of Facility <b>EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>METASTATIC CANCER (BRAIN, LUNGS)</b> Due to (or as a consequence of): b. <b>PRIMARY CARCINOMA OF BREAST</b> Due to (or as a consequence of): c. <b>—</b> Due to (or as a consequence of): d. <b>—</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>—</b>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier 				29c. License number <b>D18084</b>		29d. Date signed (Month, Day, Year) <b>DECEMBER 30, 1998</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>D.D. PATEL, M.D., 6121 MONTROSE RD, ROCKVILLE, MD 20852</b>									
31. Date filed (Month, Day, Year) <b>DEC 31 1998</b>				32. Registrar's Signature 					

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41251

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Thomas Burch Athey Jr.				2. Date of Death Month: December Day: 25, Year: 1998		3. Time of Death 2230	
	4e. Facility Name (If not institution, give street and number) Heron Point Care Facility				4b. City, Town, or Location of Death Chestertown		4c. County of Death Kent	
Funeral Director	5. Social Security Number 578-20-9396		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 93 Yrs.		8. Date of Birth (Month, Day, Year) March 3, 1905	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Kent		10c. City, Town or Location Chestertown	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 1010 Heron Point		10f. Zip Code 21620		10g. Citizen of What Country? United States	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sales person/Board of Directors		16b. Kind of Business/Industry Fertilizer			
	17. Father's Name (First, Middle, Last) Thomas Burch Athey Sr.				18. Mother's Name (First, Middle, Maiden Surname) Avarilla A. Edwards			
	19a. Informant's Name/Relationship (Type, Print) Dawn Marie Athey - Granddaughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11708 Trophy Courts, Germantown, Maryland 20876			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Crestbrook Cremation Ctr., LLC		20c. Location - City or Town, State Chester, Maryland		20d. Date December 26, 1998	
	21. Signature of Funeral Service Licensee William L. King, Jr. M-00937		22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. e. CEREBROVASCULAR ACCIDENT Due to (or as a consequence of): b. ATHEROSCLEROSIS Due to (or as a consequence of): c. Due to (or as a consequence of): d.							
	23b. Dtd tobacco use contributes to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown							
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
State Registrar	29b. Signature and title of certifier Helen H. Noble MD				29c. License number D41587		29d. Date signed (Month, Day, Year) 12/26/98	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Helen Noble, 122 Speer Road, Chestertown, MD 21620							
31. Date filed (Month, Day, Year) DEC 28 1998		32. Registrar's Signature Benita B. Sparks						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

98 41252

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>TAJ AN</b>		2. Date of Death Month Day Year <b>December 16, 1998</b>		3. Time of Death <b>1700</b>
	4a. Facility Name (If not institution, give street and number) <b>THE Johns Hopkins Hospital</b>		4b. City, Town, or Location of Death <b>Baltimore, City</b>		4c. County of Death <b>Baltimore</b>
Funeral Director	5. Social Security Number <b>326-32-0295</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>67</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>February 3, 1931</b>	9. Birthplace (State or Foreign Country) <b>Korea</b>
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State <b>Maryland</b>	10b. County <b>Kent</b>	10c. City, Town or Location <b>Chestertown</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number <b>203 Rolling Road</b>		10f. Zip Code <b>21620</b>	10g. Citizen of What Country? <b>USA</b>	
To Be Completed by Physician/Medical Examiner	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. <b>Specify: Other (Asian)</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (14 or 5+) <b>10</b>		
To Be Completed by Physician/Medical Examiner	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Professor</b>		16b. Kind of Business/Industry <b>Education</b>		
	17. Father's Name (First, Middle, Last) <b>Gong Sun An</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>So Goon Kwon</b>		
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Sihn Ja An/Wife</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>203 Rolling Road, Chestertown, Maryland 21620</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>St. Pauls Cemetery</b>		20c. Location - City or Town, State <b>12/19/98 Chestertown, Maryland</b>
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Fellows, Helfenbein &amp; Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620</b>		
	23a. Part I. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.				
To Be Completed by Physician/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) <b>Pseudomonas PNEUMONIA</b>		Approximate Interval Between Onset and Death <b>1 MONTH</b>		
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>END STAGE LIVER DISEASE</b>		Due to (or as a consequence of): <b>1 YEAR.</b>		
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
To Be Completed by Physician/Medical Examiner	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		
	28a. Date of Injury (Month, Day, Year) <b>12/19/98</b>		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
To Be Completed by Physician/Medical Examiner	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier  <b>EMERGENCY PHYSICIAN</b>		29c. License number <b>RES-000</b>		29d. Date signed (Month, Day, Year) <b>16 DECEMBER 1998</b>
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>JAMES EDWARD BEHL 600 NORTH WOLF ST BALTIMORE MARYLAND 21287-9106</b>				
To Be Completed by Physician/Medical Examiner	31. Date filed (Month, Day, Year) <b>DEC 18 1998</b>		32. Registrar's Signature 		
	State Registrar				



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State of Maryland / Department of Health and Mental Hygiene 98 41253

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>RUTH HART BERTUCH</b>				2. Date of Death Month <b>DECEMBER</b> Day <b>27</b> , Year <b>1998</b>		3. Time of Death <b>3:00PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>POTOMAC VALLEY NURSING HOME</b>				4b. City, Town, or Location of Death <b>ROCKVILLE</b>		4c. County of Death <b>MONTGOMERY</b>	
Funeral Director	5. Social Security Number <b>216-40-6969</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>85</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>DECEMBER 1, 1913</b>	9. Birthplace (State or Foreign Country) <b>ILLINOIS</b>	
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>MARYLAND</b>	10b. County <b>MONTGOMERY</b>	10c. City, Town or Location <b>ROCKVILLE</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	10e. Street and Number <b>1235 POTOMAC VALLEY ROAD</b>		10f. Zip Code <b>20850</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>3</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>EXECUTIVE SECRETARY</b>		16b. Kind of Business/Industry <b>NEW YORK BLOOD CENTER</b>			
	17. Father's Name (First, Middle, Last) <b>EDSON B. HART</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>LOUISE HOWELL</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>PENNY HUGHES (DAUGHTER)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6219 HIDDEN CANYON ROAD CENTREVILLE VA. 20120</b>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of crematory, crematory or other place) <b>MOUNT COMFORT CREMATORY</b>		Date <b>12/29/98</b>		20c. Location - City or Town, State <b>ALEXANDRIA, VIRGINIA</b>	
	21. Signature of Funeral Service Licensee <i>David E. Walley</i>				22. Name and Address of Facility <b>AFFORDABLE FUNERAL SERVICES 22027 2230 GALLOWES ROAD #110 DUNN LORING VIRGINIA</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
	Immediate Cause (Final disease or condition resulting in death) a. <i>multiple organ failure</i> Due to (or as a consequence of): b. <i>multiple underlying chronic diseases</i> Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>Alan R. Segal MD</i>				29c. License number <b>D50261</b>		29d. Date signed (Month, Day, Year) <b>12-30-98</b>		
30. Name and address of person who completed cause of death (item 23a) (Type, Print) <b>ALAN R. SEGAL MD 1299 LAMBERTON DR. SILVER SPRING MD 20902</b>								
31. Date filed (Month, Day, Year) <b>DEC 31 1998</b>				32. Registrar's Signature <i>B. Sparks</i>				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar





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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41254

Baltimore, Maryland 21215-0020  
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.


Division of Vital Records, P.O. Box 68760,  
 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
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Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>JOSEPH JACOB BOGART</b>				2. Date of Death Month Day Year <b>DEC 23 1998</b>		3. Time of Death <b>3:46 PM</b>	
4a. Facility Name (If not institution, give street and number) <b>NATIONAL NAVAL MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>BETHESDA</b>		4c. County of Death <b>MONTGOMERY</b>	
5. Social Security Number <b>085-16-5609</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>76 Yrs.</b>	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Jan. 22, 1922</b>	9. Birthplace (State or Foreign Country) <b>Vermont</b>
Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Chevy Chase</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>4712 DeRussey Parkway</b>				10f. Zip Code <b>20815</b>		10g. Citizen of What Country? <b>United States</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1943-1965</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5+</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Engineer</b>		16b. Kind of Business/Industry <b>Department of Defense</b>	
17. Father's Name (First, Middle, Last) <b>William A. Bogart</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Grace Federal</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Rita F. Bogart/Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4712 DeRussey Pkwy., Chevy Chase, Maryland 20815</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Arlington National Cemetery</b>		Date <b>Jan. 13, 1999</b>		20c. Location - City or Town, State <b>Arlington, Virginia</b>	
21. Signature of Funeral Service Licensee  <b>M00198</b>		22. Name and Address of Facility <b>Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  e. <b>SEPTIC SHOCK</b> Due to (or as a consequence of):  f. <b>MULTI ORGAN SYSTEM FAILURE</b> Due to (or as a consequence of):  g. <b>CUSHINGS SYNDROME</b> Due to (or as a consequence of):  h. Due to (or as a consequence of):  i. Due to (or as a consequence of):  j. Due to (or as a consequence of):  k. Due to (or as a consequence of):  l. Due to (or as a consequence of):  m. Due to (or as a consequence of):  n. Due to (or as a consequence of):  o. Due to (or as a consequence of):  p. Due to (or as a consequence of):  q. Due to (or as a consequence of):  r. Due to (or as a consequence of):  s. Due to (or as a consequence of):  t. Due to (or as a consequence of):  u. Due to (or as a consequence of):  v. Due to (or as a consequence of):  w. Due to (or as a consequence of):  x. Due to (or as a consequence of):  y. Due to (or as a consequence of):  z. Due to (or as a consequence of):  aa. Due to (or as a consequence of):  ab. Due to (or as a consequence of):  ac. Due to (or as a consequence of):  ad. Due to (or as a consequence of):  ae. Due to (or as a consequence of):  af. Due to (or as a consequence of):  ag. Due to (or as a consequence of):  ah. Due to (or as a consequence of):  ai. Due to (or as a consequence of):  aj. Due to (or as a consequence of):  ak. Due to (or as a consequence of):  al. Due to (or as a consequence of):  am. Due to (or as a consequence of):  an. Due to (or as a consequence of):  ao. Due to (or as a consequence of):  ap. Due to (or as a consequence of):  aq. Due to (or as a consequence of):  ar. Due to (or as a consequence of):  as. Due to (or as a consequence of):  at. Due to (or as a consequence of):  au. Due to (or as a consequence of):  av. Due to (or as a consequence of):  aw. Due to (or as a consequence of):  ax. Due to (or as a consequence of):  ay. Due to (or as a consequence of):  az. Due to (or as a consequence of):  ba. Due to (or as a consequence of):  bb. Due to (or as a consequence of):  bc. Due to (or as a consequence of):  bd. Due to (or as a consequence of):  be. Due to (or as a consequence of):  bf. Due to (or as a consequence of):  bg. Due to (or as a consequence of):  bh. Due to (or as a consequence of):  bi. Due to (or as a consequence of):  bj. Due to (or as a consequence of):  bk. Due to (or as a consequence of):  bl. Due to (or as a consequence of):  bm. Due to (or as a consequence of):  bn. Due to (or as a consequence of):  bo. Due to (or as a consequence of):  bp. Due to (or as a consequence of):  bq. Due to (or as a consequence of):  br. Due to (or as a consequence of):  bs. Due to (or as a consequence of):  bt. Due to (or as a consequence of):  bu. Due to (or as a consequence of):  bv. 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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **98 41255**  
Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Ruth Twocrow Brokenrope

2. Date of Death

Month Day Year  
December 24 1998

3. Time of Death

12:20pm

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

375-20-8659

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Feb. 19, 1919

9. Birthplace (State or Foreign Country)

South Dakota

Usual Residence of Decedent

10e. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1108 Oakview Drive

10f. Zip Code

20903

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:  
American Indian

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (14 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Employee Relations

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

George Two Crow

18. Mother's Name (First, Middle, Maiden Surname)

Annie Marshall

19a. Informant's Name/Relationship (Type, Print)

Deborah Ann Brokenrope (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1108 Oakview Drive Silver Spring, Maryland 20903

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Black Hills National Cemetery

Date

12/31/98

20c. Location - City or Town, State

Sturgis, South Dakota

21. Signature of Funeral Service Licensee

Tracy L. Stuver

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.  
500 University Blvd., W., Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory Failure

Due to (or as a consequence of):

14 days

b. Renal Failure

Due to (or as a consequence of):

14 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Antibiotic Resistant Urinary Tract Infection

Due to (or as a consequence of):

10 days

d. Aspiration Pneumonia

14 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Obstructive Pulmonary Disease

Marasmus

Osteoporosis and chronic pain syndrome

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

John L. Sato, M.D.

29c. License number

D44120

29d. Date signed (Month, Day, Year)

December 24, 1998

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Takao L. Sato, M.D. 14816 Physicians Lane Suite 152, Rockville, Maryland

31. Date filed (Month, Day, Year)

DEC 28 1998

32. Registrar's Signature

B. Sparks

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

10



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

38 41256

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) David Brown				2. Date of Death Month Day Year Dec 23, 1998				3. Time of Death 04:00am		
	4a. Facility Name (If not institution, give street and number) Holy Cross Hospital				4b. City, Town, or Location of Death Silver Spring				4c. County of Death Montgomery		
Funeral Director	5. Social Security Number 577-44-6127	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 64 Yrs.	8. Date of Birth (Month, Day, Year) June 18, 1934	9. Birthplace (State or Foreign Country) Washington, D.C.						
	Usual Residence of Decedent										
To Be Completed by Funeral Director	10a. State Maryland	10b. County Prince George's	10c. City, Town or Location Adelphi		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						
	10e. Street and Number 1906 Wooded Way			10f. Zip Code 20783		10g. Citizen of What Country? United States					
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Entrepreneur/ Owner				16b. Kind of Business/Industry Dave Brown Wine and Liquor Store				
	17. Father's Name (First, Middle, Last) William David Brown				18. Mother's Name (First, Middle, Maiden Surname) Ruby Johnson						
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) David W. Brown /SON				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11112 Lake Arbor Way Mitchellville, Md. 20721						
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Olivet Cemetery		20c. Location - City or Town, State Washington, D.C.						
	21. Signature of Funeral Service Licensee Lynne McGuire				22. Name and Address of Facility McGuire Funeral Service, Inc. 7400 Georgia Ave., N.W. Wash., D.C. 20012						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. non-small cell lung cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):										
	23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No										
State Registrar	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. pneumonia				25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						
	26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)				27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined						
	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
29b. Signature and title of certifier Roy Fried MD				29c. License number D34590				29d. Date signed (Month, Day, Year) 12-23-1998			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Roy Fried, MD, Kaiser Office, Holy Cross Hospital, address in item 4.											
31. Date filed (Month, Day, Year) DEC 28 1998				32. Registrar's Signature B. Sparks							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>CARL BUCKNER</b>				2. Date of Death Month <b>Dec.</b> Day <b>22</b> Year <b>1998</b>		3. Time of Death <b>11:10P.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>MARINER HEALTH &amp; REHABILITATION CENTER</b>				4b. City, Town, or Location of Death <b>SILVER SPRING</b>		4c. County of Death <b>MONTGOMERY</b>	
Funeral Director	5. Social Security Number <b>577 60 1957</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>93</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Oct. 25, 1905</b>	9. Birthplace (State or Foreign Country) <b>Washington, D.C.</b>
	Usual Residence of Decedent				10c. City, Town or Location <b>Washington, D.C.</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. State <b>N/A</b>		10b. County <b>N/A</b>		10f. Zip Code <b>20002</b>		10g. Citizen of What Country? <b>United States</b>		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: <b>5/14/43 - 11/19/43</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. <b>Specify African American</b>
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>1</b> College (1-4 or 5+) <b>1</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Messenger</b>		16b. Kind of Business/Industry <b>Federal Government</b>		
17. Father's Name (First, Middle, Last) <b>Henry Buckner</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mantie E. Mills</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Doris Wills/Personal Rep</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5212 Eastern Avenue, N.E. Washington, D.C. 20011</b>				
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Chesapeake Crematory Inc</b>		Date <b>12/26/98</b>		20c. Location - City or Town, State <b>Beltsville, MD</b>
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <b>McGuire Funeral Service, Inc. 20012</b> <b>7400 Georgia Avenue, N.W. Washington, D.C.</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. respiratory failure</b> Due to (or as a consequence of): <b>b. Congestive Heart Failure</b> Due to (or as a consequence of): <b>c. renal failure</b> Due to (or as a consequence of): <b>d. acute tubular necrosis</b>								Approximate Interval Between Onset and Death <b>2 days</b> <b>1 year</b> <b>2-3 months</b> <b>2-3 months</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>deep褥疮 (sacral)</b> <b>urosepsis</b>						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				
28f. Location (Street and Number or Rural Route Number, City or Town, State)				28g. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>[Signature]</i>				29c. License number <b>039372</b>		29d. Date signed (Month, Day, Year) <b>December 22, 1998</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>RASHID BACHAT - NAINI</b> <b>344 UNIVERSITY BLVD NW</b> <b>SILVER SPRING MD 20901</b>								
31. Date filed (Month, Day, Year) <b>DEC 28 1998</b>				32. Registrar's Signature <i>[Signature]</i>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner






Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

Reg. No.

98 41258

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JOHN HILLIKER BURCHARD</b>						2. Date of Death Month Day Year <b>DEC. 21, 1998</b>		3. Time of Death <b>11:10 PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>WILSON HEALTH CARE CENTER</b>						4b. City, Town, or Location of Death <b>GAITHERSBURG</b>		4c. County of Death <b>MONTGOMERY</b>		
Funeral Director	5. Social Security Number <b>217-44-0037</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>86</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>JAN. 15, 1912</b>		9. Birthplace (State or Foreign Country) <b>ILLINOIS</b>		
	Usual Residence of Decedent										
10a. State <b>MD.</b>		10b. County <b>MONTGOMERY</b>		10c. City, Town or Location <b>GAITHERSBURG</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10e. Street and Number <b>403 RUSSELL AVE. #704</b>				10f. Zip Code <b>20877</b>				10g. Citizen of What Country? <b>U.S.A.</b>			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5+</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>RET. - EMPLOYEE</b>				16b. Kind of Business/Industry <b>FEDERAL GOV'T.</b>			
17. Father's Name (First, Middle, Last) <b>GEORGE WASHINGTON BURCHARD III</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>HELEN HILLIKER</b>					
19a. Informant's Name/Relationship (Type, Print) <b>RUTH B. BURCHARD/WIFE</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>SAME AS ITEM #10</b>					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>CHAMBERS CREMATORY</b>		Data <b>12/23/98</b>		20c. Location - City or Town, State <b>RIVERDALE, MD.</b>			
21. Signature of Funeral Service Licensee  <b>MOOO91</b>				22. Name and Address of Facility <b>CHAMBERS FUNERAL HOMES, P.A., SILVER SPRING, MD. 20910</b>							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Aspiration Pneumonitis</b> Due to (or as a consequence of): b. <b>Prior Cerebral Vascular Accident</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death <b>2 wks</b>  <b>years</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Parkinson's Disease, Dementia, Hypertension</b>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
								24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
				28d. Describe how Injury occurred							
				28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify)							
				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 				29c. License number <b>041794</b>			
				29d. Date signed (Month, Day, Year) <b>December 22, 1998</b>							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Priscilla Callahan-Lyon 911 Russell Ave Gaithersburg, MD 20879</b>											
31. Date filed (Month, Day, Year) <b>DEC 28 1998</b>				32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 98 4 1259

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Robert Lee BURGER Jr.</b>				2. Date of Death Month <b>December</b> Day <b>22</b> Year <b>1998</b>		3. Time of Death <b>3:06 pm</b>		
	4a. Facility Name (If not institution, give street and number) <b>Route 75 @ Price's Distillery Road</b>				4b. City, Town, or Location of Death <b>Ijamsville</b>		4c. County of Death <b>Frederick</b>		
Funeral Director	5. Social Security Number <b>217 98 9964</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>18</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>FEB 17, 1980</b>		
	9. Birthplace (State or Foreign) <b>MARYLAND</b>		10a. State <b>MD.</b>		10b. County <b>MONTGOMERY</b>		10c. City, Town or Location <b>GERMANTOWN</b>		
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>12732 SESAME SEED COURT</b>		10f. Zip Code <b>20874</b>		10g. Citizen of What Country? <b>UNITED STATES</b>	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>LABORER</b>		16b. Kind of Business/Industry <b>WAREHOUSE</b>		17. Father's Name (First, Middle, Last) <b>ROBERT L. BURGER</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>SHANNAH J. DOVE</b>	
19a. Informant's Name/Relationship (Type, Print) <b>SHANNAH J. DOVE-HASH, MOTHER</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>12732 SESAME SEED COURT, GERMANTOWN, MD. 20874</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>PARKLAWN CEMETERY</b>		20c. Location - City or Town, State <b>12/28/98 ROCKVILLE, MD.</b>	
21. Signature of Funeral Service Licensee 		21. Name and Address of Funeral Home <b>MURIEL H. BARBER FUNERAL HOME P.O. BOX 5038, LAYTONSVILLE, MD. 20882</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>e. Multiple Traumatic Injuries</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>f. Immed.</b>		Approximate Interval Between Onset and Death <b>Immed.</b>			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Roadway</b>		27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>Dec 22, 1998</b>		28b. Time of Injury <b>2:55 p M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>Rear-seat passenger in car/truck collision</b>		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>Street</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>Route 75 &amp; Price's Distillery Rd, Ijamsville, MD</b>			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>D35164</b>		29d. Date signed (Month, Day, Year) <b>December 23, 1998</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Andrew Zarick, Jr, MD, 1080 West Patrick Street, Frederick, Maryland 21703</b>		31. Date filed (Month, Day, Year) <b>DEC 29 1998</b>		32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

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Physician  
/Medical  
Examiner

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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 41260

ANTHONY GORDON BRIDGE

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ANTHONY GORDON BRIDGE</b>				2. Date of Death Month: <b>DEC.</b> Day: <b>18</b> , Year: <b>1998</b>		3. Time of Death <b>0245 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>GLEBE ROAD/400 YARDS FROM UNIONVILLE ROAD</b>				4b. City, Town, or Location of Death <b>EASTON</b>		4c. County of Death <b>TALBOT</b>	
Funeral Director	5. Social Security Number <b>212-78-5161</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>28</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Nov. 3, 1970</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>Talbot</b>		10c. City, Town or Location <b>Bozman</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>8013 Ruby Harrison Rd.</b>		10f. Zip Code <b>21612</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): <b>9</b> College (1-4 or 5+):		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Waterman</b>		16b. Kind of Business/Industry <b>Seafood</b>				
17. Father's Name (First, Middle, Last) <b>Gordon Lee Bridge</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Sandra Sue Bridges</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Sue B. Bridge Mother</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P.O. Box 50, Bozman, Maryland 21612</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Bozman Cemetery</b>		20c. Location - City or Town, State <b>Dec. 29, 1998 Bozman, Maryland</b>				
21. Signature of Funeral Service Licensee <i>Harrison E. Leonard</i>				22. Name and Address of Facility <b>Harrison E. Leonard Funeral Home 312 S. Talbot St. St. Michaels, Maryland 21663</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Multiple Injuries</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>AT SCENE</b>						
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>12/18/98</b>		28b. Time of Injury <b>216 AM</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred <b>motor vehicle accident</b>		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>street</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>Easton, Talbot Co., Md</b>				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>Dennis J. Chute, MD</i>				29c. License number <b>O.C.M.E</b>		29d. Date signed (Month, Day, Year) <b>DEC. 19, 1998</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dennis J. Chute, MD 111 Penn Street, Baltimore, Maryland 21201</b>								
31. Date filed (Month, Day, Year) <b>DEC 30 1998</b>		32. Registrar's Signature <i>B. Sparks</i>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41261

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Marish Bailey</i>				2. Date of Death Month <i>12</i> Day <i>18</i> Year <i>98</i>		3. Time of Death <i>10:48 PM</i>	
	4a. Facility Name (If not institution, give street and number) <i>Mallard Bay Care Center</i>				4b. City, Town, or Location of Death <i>Camd. Md.</i>		4c. County of Death <i>Dorchester</i>	
Funeral Director	5. Social Security Number <i>227-10-6514</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>85</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>Feb. 13, 1913</i>	9. Birthplace (State or Foreign Country) <i>Virginia</i>
	Usual Residence of Decedent							
10e. State <i>Maryland</i>		10b. County <i>Dorchester</i>		10c. City, Town or Location <i>Cambridge</i>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <i>520 Glenburn Ave.</i>				10f. Zip Code <i>21613</i>		10g. Citizen of What Country? <i>USA</i>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>Unknown</i> Collage (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Homemaker</i>			16b. Kind of Business/Industry <i>Someone else's home</i>	
17. Father's Name (First, Middle, Last) <i>George Jenkins</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Mary Elizabeth Johnson</i>				
19a. Informant's Name/Relationship (Type, Print) <i>Eleanore Hankerson, sister</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>913 B Booth Street, Salisbury, Maryland 21801</i>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Bethel Cemetery</i>		Date <i>12/28/98</i>		20c. Location - City or Town, State <i>Cambridge, Maryland</i>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <i>Bennie Smith Funeral Home P.O. Box 1687, Easton, Maryland 21601</i>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) e. <i>ASCVD</i> Due to (or as a consequence of): b. <i>Toe Ulcer</i> Due to (or as a consequence of): c. <i>Cu of Breast Metastasis</i> Due to (or as a consequence of): d.  Approximate Interval Between Onset and Death <i>10 yrs.</i> <i>1 wk.</i> <i>1 yr.</i>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>Dr. [Signature]</i> <i>attender</i>				29c. License number <i>D15541</i>		29d. Date signed (Month, Day, Year) <i>12/19/98</i>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <i>VINODRAI MEHTA 300 AURORA ST CAMBRIDGE, MD 21613</i>								
31. Date filed (Month, Day, Year) <i>DEC 28 1998</i>		32. Registrar's Signature <i>B. Sparks</i>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41262

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Gerda MARIA Bowers</b>					2. Date of Death Month Day Year <b>December 15 1998</b>		3. Time of Death <b>8 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>GBMC</b>					4b. City, Town, or Location of Death <b>Towson</b>		4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>218-18-5184</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>74</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>June 19, 1924</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent								
10a. State <b>Maryland</b>		10b. County <b>Carroll</b>		10c. City, Town or Location <b>Westminster</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10a. Street and Number <b>1054 Klee Mill Rd.</b>			10f. Zip Code <b>21157</b>			10g. Citizen of What Country? <b>USA</b>			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>white</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>0</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Secretary</b>			16b. Kind of Business/Industry <b>Teamsters Union</b>			
17. Father's Name (First, Middle, Last) <b>Alouis Geier</b>					18. Mother's Name (First, Middle, Maiden Summa) <b>Helena Kertzel</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Gail Bowers (Daughter)</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10000 2 Old Providence Way Cockeysville MD 21030</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Trinity Lutheran Cem.</b>		Date <b>12/18/98</b>		20c. Location - City or Town, State <b>Taneytown, MD</b>		
21. Signature of Funeral Service Licensee <b>John K. Riley</b>					22. Name and Address of Facility <b>Pritts Funeral Home and Chapel, P.A. 412 Washington Rd Westminster MD 21157</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) <b>ischemic Heart Disease</b>									<b>years</b>
Due to (or as a consequence of): <b>Hypertension</b>									<b>years</b>
Due to (or as a consequence of):									
Due to (or as a consequence of):									
Due to (or as a consequence of):									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>diabetes mellitus</b> <b>renal failure</b>									
23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown									
24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b>						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29b. Signature and title of certifier <b>John K. Riley, MD</b>			29c. License number <b>025205</b>		29d. Date signed (Month, Day, Year) <b>December 21, 1998</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>W.A. Riley GBMC 6701 N. Charles St. Balto. MD 21204</b>									
31. Date filed (Month, Day, Year) <b>DEC 30 1998</b>			32. Registrar's Signature <b>Denise P. Sparks</b>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41263

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last) <b>Peggy Juanita Blake</b>				2. Date of Death Month <b>December</b> Day <b>27</b> Year <b>1998</b>		3. Time of Death <b>1903</b>	
4a. Facility Name (If not institution, give street and number) <b>Kent &amp; Queen Anne's Hospital</b>				4b. City, Town, or Location of Death <b>Chestertown</b>		4c. County of Death <b>Kent</b>	
5. Social Security Number <b>215-36-0713</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>60 Yrs.</b>		8. Date of Birth (Month, Day, Year) <b>Dec. 23, 1938</b>	
9. Birthplace (State or Foreign Country) <b>Maryland</b>		10. Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County <b>Kent</b> 10c. City, Town or Location <b>Worton</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>10967 Bottom Road</b>	
10f. Zip Code <b>21678</b>		10g. Citizen of What Country? <b>USA</b>		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> Collage (1-4 or 5+) <b>Collage</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Private Nursing</b>	
16b. Kind of Business/Industry <b>Nursing/ Health Care</b>		17. Father's Name (First, Middle, Last) <b>James E. Wilson</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Mable Hynson</b>		19a. Informant's Name/Relationship (Type, Print) <b>Horace Blake, Husband</b>	
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P.O. Box 154, Worton, Maryland 21678</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>St. Georges Cemetery</b>		20c. Location - City or Town, State <b>01/2/99 Worton, Md.</b>	
21. Signature of Funeral Director 		22. Name and Address of Facility <b>Bennie Smith Funeral Home</b> <b>P.O. Box 1687, Easton, Maryland 21601</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>ACUTE MI</b>		Approximate Interval Between Onset and Death <b>Days</b>	

To Be Completed by Funeral Director

Physician  
/Medical  
Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>ACUTE MI</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
23c. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Diabetes</b>		24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicida <input type="checkbox"/> Homicida <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined	
28a. Date of Injury (Month, Day Year) <b>12/21/98</b>		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. Signature and title of certifier 		29c. License number <b>D36054</b>	
29d. Date signed (Month, Day, Year) <b>12/21/98</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Patricia Shanahan MD 100 Brown Street, Chestertown, Md. 21620</b>	

To Be Completed by Physician/Medical Examiner

State  
Registrar

31. Date filed (Month, Day, Year) <b>DEC 30 1998</b>		32. Registrar's Signature 	
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Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41264

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Florence Virgin Bakewell</b>				2. Date of Death Month Day Year <b>Dec 27 1998</b>		3. Time of Death <b>7:05PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Genesis ElderCare - The Pines</b>				4b. City, Town, or Location of Death <b>Easton</b>		4c. County of Death <b>Talbot</b>	
Funeral Director	5. Social Security Number <b>175-12-9948</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>100</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Nov. 21, 1898</b>	
	9. Birthplace (State or Foreign Country) <b>Bethlehem, PA</b>		10a. State <b>MD</b>		10b. County <b>Talbot</b>		10c. City, Town or Location <b>Easton</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>610 Dutchmans Lane</b>		10f. Zip Code <b>21601</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>0</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>own home</b>				
17. Father's Name (First, Middle, Last) <b>James Virgin</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Rebecca Livingston</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Mildred G. Gasbarre/Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1200 S. Washington St., Apt 1402, Easton, MD 21601</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Chesapeake Cremation Center, L.L.C.</b>		Date <b>12/29/98</b>		20c. Location - City or Town, State <b>Chester, MD</b>		
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Fellows, Helfenbein, &amp; Newnam Funeral Home, P.A., 200 South Harrison Street, Easton, Md 21601</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. DENYDRATION</b> Due to (or as a consequence of): <b>b. ANEMIA</b> Due to (or as a consequence of): <b>c. HYPERTENSION</b> Due to (or as a consequence of): <b>d. SENILE DEMENTIA</b>								
Approximate Interval Between Onset and Death <b>DAYS</b> <b>YEARS</b> <b>YEARS</b> <b>YEARS</b>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DEPRESSION</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 		29c. License number <b>H48241</b>		29d. Date signed (Month, Day, Year) <b>12/28/98</b>				
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) <b>DANIEL E. MAKAS, PO 508 IDEWILD AVE EASTON, MD 21601</b>								
31. Date filed (Month, Day, Year) <b>DEC 29 1998</b>		32. Registrar's Signature 						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician  
/Medical  
Examiner

Funeral  
Director

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 41265

Physician  
/Medical  
Examiner

Funeral  
Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1. Decedent's Name (First, Middle, Last) <b>STANLEY JEROME BENJAMIN</b>		2. Date of Death Month <b>DECEMBER</b> Day <b>28</b> Year <b>1998</b>		3. Time of Death <b>7:54am</b>	
4a. Facility Name (If not institution, give street and number) <b>WILLIAM HILL MANOR</b>			4b. City, Town, or Location of Death <b>EASTON</b>		4c. County of Death <b>TALBOT</b>
5. Social Security Number <b>111-09-0408</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>89</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Dec. 6, 1909</b>
9. Birthplace (State or Foreign Country) <b>New York</b>					
Usual Residence of Decedent					
10a. State <b>Maryland</b>	10b. County <b>Talbot</b>	10c. City, Town or Location <b>Easton</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>501 Dutchman's Lane</b>		10f. Zip Code <b>201</b>		10g. Citizen of What Country? <b>United States</b>	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Representative/Agent</b>		16b. Kind of Business/Industry <b>Insurance</b>	
17. Father's Name (First, Middle, Last) <b>Eugene Benjamin</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Margaret Lorschbach</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Gretchen Van Bourgondien/Sister</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>26406 Arcadia Shores Circle, Easton, MD 21601</b>		
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Chesapeake Cremation Center, LLC</b>		20c. Location - City or Town, State <b>Stevensville, Maryland</b>	
21. Signature of Funeral Service Licensee <b>JOHN R. MERLESON</b>		22. Name and Address of Facility <b>Fellows, Helfenbein &amp; Newnam Funeral Home, P.A. 200 S. Harrison Street, Easton, Maryland 21601</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>CEREBROVASCULAR ACCIDENT</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last {  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ATRIAL FLUTTER - FIBRILLATION</b> <b>SEIZURE DISORDER</b> <b>URINARY INCONTINENCE</b>					
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <b>M</b>		28b. Time of Injury <b>1</b> Yes <b>2</b> No	
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28b. Describe how injury occurred			
28c. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <b>W. S. BREMER MD</b>		29c. License number <b>D26350</b>		29d. Date signed (Month, Day, Year) <b>12/28/98</b>	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>William S. Bremer MD 800 S. Talbot St. St. Michaels MD 21663</b>					
31. Date filed (Month, Day, Year) <b>DEC 29 1998</b>		32. Registrar's Signature <b>B. Spauld</b>			

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

08 41266

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Ethel May Barr

2. Date of Death

Month  
Dec.Day  
18Year  
1998

3. Time of Death

4:25 AM

4a. Facility Name (If not institution, give street and number)

Anne Arundel Medical Center

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

Funeral  
Director

5. Social Security Number

176-20-3361

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

69

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

March 8, 1929

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10e. State

MD

10b. County

Queen Anne's

10c. City, Town or Location

Stevensville

10d. Inside City Limits

1 ☐ Yes 2 ☐ No

10e. Street and Number

P.O. Box #2, 107 Davidson Road

10f. Zip Code

21666

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Self

17. Father's Name (First, Middle, Last)

Benjamin Stipe

18. Mother's Name (First, Middle, Maiden Surname)

Mabel Pierce

19a. Informant's Name/Relationship (Type, Print)

William D. Barr Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box #2, 107 Davidson Road, Stevensville, MD 21666

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Chesapeake Cremation Ctr.

Date

Dec. 18, 1998

20c. Location - City or Town, State

Stevensville, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Fellows, Helfenbein & Newnam Funeral Home P.A.  
106 Shamrock Road, Chester, MD 2161923a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e.

intracranial hemorrhage

Due to (or as a consequence of):

b.

atherosclerotic vascular disease

Due to (or as a consequence of):

c.

hyperlipidemia

Due to (or as a consequence of):

d.

diabetes mellitus type 2

Approximate  
Interval Between  
Onset and Death

1 day

20 yrs

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

congestive heart failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury et  
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

044161

29d. Date signed (Month, Day, Year)

12-18-98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Patricia Czapp MD 200 Truman Parkway Annapolis MD 21401

State  
Registrar

31. Date filed (Month, Day, Year)

DEC 22 1998

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural," or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

38 41267

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LOUIS SHIRLEY CLAPPER				2. Date of Death Month Day Year DECEMBER 22, 1998		3. Time of Death 11:15 A.M.	
	4a. Facility Name (If not institution, give street and number) 12636 BILLINGTON ROAD				4b. City, Town, or Location of Death SILVER SPRING		4c. County of Death MONTGOMERY	
Funeral Director	5. Social Security Number 486-14-0105		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 82 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) NOV. 10, 1916	9. Birthplace (State or Foreign Country) MISSOURI
	Usual Residence of Decedent							
10a. State MARYLAND		10b. County MONTGOMERY		10c. City, Town or Location SILVER SPRING			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 12636 BILLINGTON ROAD				10f. Zip Code 20904		10g. Citizen of What Country? UNITED STATES OF AMERICA		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1942-1945		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) EDITORIALIST CONSERVATIONIST			16b. Kind of Business/Industry NATIONAL WILDLIFE FEDERATION	
17. Father's Name (First, Middle, Last) ODEN HENRY CLAPPER				18. Mother's Name (First, Middle, Maiden Surname) LAURA JETTA SHIRLEY				
19a. Informant's Name/Relationship (Type, Print) GRACE A. CLAPPER (WIFE)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12636 BILLINGTON ROAD SILVER SPRING MARYLAND 20904				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) PARKLAWN MEMORIAL PARK		Date DEC. 24, 1998		20c. Location - City or Town, State ROCKVILLE MARYLAND
21. Signature of Funeral Service Licensee <i>Sam S. Schwartz</i>				22. Name and Address of Facility HINES-RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVENUE SILVER SPRING MARYLAND 20904-2891				
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. LUNG CANCER Due to (or as a consequence of):  b. COPD Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how Injury occurred				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>Sam S. Schwartz MD</i>				29c. License number D18813		29d. Date signed (Month, Day, Year) 12/23/98		
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) IRA TAUBER, M.D., 10301 GEORGIA AVENUE SILVER SPRING MARYLAND 20902								
31. Date filed (Month, Day, Year) DEC 29 1998				32. Registrar's Signature <i>Anna B. Sparks</i>				

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41268

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Sylvia Colbreuner</b>				2. Date of Death Month Day Year <b>Dec. 27 1998</b>		3. Time of Death <b>7:00 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Hebrew Home of Greater Washington</b>				4b. City, Town, or Location of Death <b>Rockville</b>		4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>057-01-5177</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>85</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Jan. 24 1913</b>	9. Birthplace (State or Foreign Country) <b>Brooklyn, NY</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>MD</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Rockville</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number <b>6121 Montrose Road</b>				10f. Zip Code <b>20852</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Legal Secretary</b>		16b. Kind of Business/Industry <b>DC Juvenile Court</b>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>Herman Friedman</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Hermine Klein</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Myron Colbreuner/Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5225 Connecticut Ave. Washington, DC 20015</b>			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Judean Mem. Gardens</b>		Date <b>12/29/98</b>		20c. Location - City or Town, State <b>Olney, MD</b>	
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <b>Ives-Pearson Funeral Home 2847 Wilson Blvd. Arlington, DC 22201</b>			
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>CEREBROVASCULAR ACCIDENT</b> Due to (or as a consequence of): b. <b>CEREBRAL ARTERIOSCLEROSIS</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death <b>2 WEEKS</b> <b>YEARS</b>
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ISCHEMIC CARDIOMYOPATHY</b> <b>ASPIRATION PNEUMONITIS</b>							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
State Registrar	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred					
	28f. Location (Street and Number or Rural Route Number, City or Town, State)		28e. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
State Registrar	29b. Signature and title of certifier <b>Steven Lipson MD</b>				29c. License number <b>D 05885</b>		29d. Date signed (Month, Day, Year) <b>12/28/98</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>STEVEN LIPSON 6121 MONTROSE RD, ROCKVILLE</b>							
State Registrar	31. Date filed (Month, Day, Year) <b>DEC 30 1998</b>		32. Registrar's Signature <i>[Signature]</i>					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41269

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Edwin W. Cimokowski

2. Date of Death  
Month Day Year

December 28, 1998

3. Time of Death

9:50AM

4a. Facility Name (If not Institution, give street and number)

Laurel Regional Hospital

4b. City, Town, or Location of Death

Laurel

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

577-38-8084

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

83

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

Feb. 8, 1915

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

10b. County

10c. City, Town or Location

Maryland Prince George's

Hyattsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6604 Ian Street

10f. Zip Code

20784

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married

3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

5+

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Attorney

16b. Kind of Business/Industry

Law

17. Father's Name (First, Middle, Last)

Frank Cimokowski

18. Mother's Name (First, Middle, Maiden Surname)

Josephine Pelczarska

19a. Informant's Name/Relationship (Type, Print)

Constance D. Cornelsen

(daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8403 Snowden Loop Court Laurel, Maryland 20708

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate of Heaven Cemetery 12/31/98 Silver Spring, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Steven D. Stancel

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd., W., Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Aspiration Pneumonia

Due to (or as a consequence of):

b. Cerebrovascular Accident

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

5 days

5 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Prostate Cancer

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural

2 ☐ Accident

3 ☐ Suicide

4 ☐ Homicide

5 ☐ Pending investigation

6 ☐ Could not be determined

28a. Date of Injury  
(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Michael Berard, MD

29c. License number

D 26287

29d. Date signed (Month, Day, Year)

12/29/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M BERARD

7305 BALTIMORE AVE

COLLEGE PARK MD 20740

31. Date filed (Month, Day, Year)

DEC 31 1998

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41270

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ARTHUR L. COOK</b>				2. Date of Death Month Day Year <b>Dec 29, 1998</b>				3. Time of Death <b>9:32 AM</b>	
	4a. Facility Name (If not Institution, give street and number) <b>Suburban Hospital</b>				4b. City, Town, or Location of Death <b>Bethesda</b>				4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>223-20-8369A</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>76</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>May 20, 1922</b>		9. Birthplace (State or Foreign Country) <b>Virginia</b>	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <b>Md</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Potomac</b>				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number <b>7701 Scotland Drive</b>				10f. Zip Code <b>20854</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5th Grade</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Mechanic</b>			16b. Kind of Business/Industry <b>Stone Co. Rockville Crush</b>		
	17. Father's Name (First, Middle, Last) <b>Nelson Cook</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Frances Parham</b>				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Ellavee P. Cook (Wife)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7701 Scotland Drive, Potomac, Md 20854</b>					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gate Of Heaven Cem.</b>		Date <b>1/2/99</b>		20c. Location - City or Town, State <b>Silver Spring, Md</b>			
	21. Signature of Funeral Service Licensee <i>George R. Snowden</i>				22. Name and Address of Facility <b>Snowden Funeral Home P.A. 20850 246 N. Washington St, Rockville, Md</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Ventricular fibrillation</b> Due to (or as a consequence of): b. <b>congestive heart failure</b> Due to (or as a consequence of): c. <b>valvular heart disease</b> Due to (or as a consequence of): d. <b>coronary artery disease</b>								Approximate Interval Between Onset and Death <b>seconds</b> <b>years</b> <b>years</b> <b>years</b>	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>hypertension</b>								23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> BOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Roy Fried MD</i>		29c. License number <b>D34590</b>		29d. Date signed (Month, Day, Year) <b>12-29-98</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Roy Fried, MD; Kaiser Office, Holy Cross Hospital, 1500 Forest Glen Rd Silver Spring, MD</b>										
31. Date filed (Month, Day, Year) <b>DEC 31 1998</b>		32. Registrar's Signature <i>Benjamin B. Sparks</i>								





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41271

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Charles C Cook

2. Date of Death

Dec 22, 1998

3. Time of Death

10:40am

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

026-12-4254

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

78

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

APRIL 20, 1920

9. Birthplace (State or Foreign Country)

MASS.

Usual Residence of Decedent

10a. State

MD.

10b. County

MONTGOMERY

10c. City, Town or Location

SILVER SPRING

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2015 HARLEQUIN TERR.

10f. Zip Code

20904

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

FILE CLERK

16b. Kind of Business/Industry

V.A. ADMINISTRATION

17. Father's Name (First, Middle, Last)

GUY C. COOK

18. Mother's Name (First, Middle, Maiden Surname)

HARRIET YOUNG

19a. Informant's Name/Relationship (Type, Print)

ALTA L.A. COOK/ WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

SAME AS ITEM #10

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GATE OF HEAVEN CEMETERY

Date

12/30/98

20c. Location - City or Town, State

SILVER SPRING, MD.

21. Signature of Funeral Service Licensee

W. W. Chambers M00091

22. Name and Address of Facility

CHAMBERS FUNERAL HOMES, P.A., SILVER SPRING, MD. 20910

23a. Part I. Enter the disease, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *from septicemia*  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

48 hrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

W. W. Chambers, M.D.

29c. License number

109F34

29d. Date signed (Month, Day, Year)

Dec 27, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BARRY ROSENBAUM, M.D.

3720 Farragut Ave Kensington Md 20895

State  
Registrar

31. Date filed (Month, Day, Year)

DEC 28 1998

32. Registrar's Signature

Gene B. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41272

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

James R. Coziahr

2. Date of Death

Month Day Year  
December 26, 1998

3. Time of Death

12:40 AM

4a. Facility Name (If not institution, give street and number)

2228 Blue Valley Dr

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

353-34-5729

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

56

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Mar 8, 1942

9. Birthplace (State or Foreign Country)

Illinois

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

2228 Blue Valley Dr

10f. Zip Code

20904

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No 1970-  
If Yes, Give Year or Dates: 198513. Was Decedent of Hispanic Origin? (Specify Yes or No -  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working  
life. DO NOT use retired)

Airline Employee

16b. Kind of Business/Industry

American Airlines

17. Father's Name (First, Middle, Last)

Arthur B. Coziahr

18. Mother's Name (First, Middle, Maiden Surname)

Faye Seward

19a. Informant's Name/Relationship (Type, Print)

Barbara Ann Coziahr/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2228 Blue Valley Dr, Silver Spring, MD 20904

20a. Method of Disposition

☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Oak Lawn Memorial Gardens Dec 30 Galesburg, Illinois

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

▶ Alan J. Donnell

22. Name and Address of Facility Hines-Rinaldi Funeral Home

11800 New Hampshire Ave, Silver Spring, MD 20904

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

Pancreatic Cancer

Approximate  
Interval Between  
Onset and Death

17 months

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

▶ Jill Gilbert

29c. License number

md 00053077

29d. Date signed (Month, Day, Year)

December 26, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jill Gilbert 6112 Bellinham, #531, Baltimore, MD 21210

State  
Registrar

31. Date filed (Month, Day, Year)

DEC 29 1998

32. Registrar's Signature

Geneva B. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41273

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Oscar B. Crist, Jr.				2. Date of Death Month Day Year December 24, 1998		3. Time of Death 9:50 AM		
	4a. Facility Name (If not institution, give street and number) 12513 Piedmont Road				4b. City, Town, or Location of Death Clarksburg		4c. County of Death Montgomery		
Funeral Director	5. Social Security Number 231-24-6500		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 71 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) March 15, 1927	9. Birthplace (State or Foreign Country) Virginia	
	Usual Residence of Decedent								
10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Clarksburg			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 12513 Piedmont Road				10f. Zip Code 20871		10g. Citizen of What Country? United States			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: World War II		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collage (1-4or 5+) -				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Salesman			16b. Kind of Business/Industry Paint Company		
17. Father's Name (First, Middle, Last) Oscar B. Crist, Sr.					18. Mother's Name (First, Middle, Maiden Surname) Augusta Parker				
19a. Informant's Name/Relationship (Type, Print) David Lee Crist/ Son					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12513 Piedmont Road, Clarksburg, Maryland 20871				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Stonewall Jackson Memorial Cemetery		20c. Location - City or Town, State Lexington, Virginia		20d. Date December 27, 1998	
21. Signature of Funeral Service Licensee  000689					22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805				
23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) OAT CELL CARCINOMA OF THE RIGHT LUNG Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								Approximate Interval Between Onset and Death 5 1/2 MONTHS	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred					
28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29c. License number D07285		29d. Date signed (Month, Day, Year) December 26, 1998			
29b. Signature and title of certifier James A. Brown, MD				29e. Name and address of person who completed cause of death (Item 23a) (Type, Print) James A. Brown, MD 9707 MEDICAL CENTER DRIVE ROCKVILLE, MARYLAND					
31. Date filed (Month, Day, Year) DEC 28 1998				32. Registrar's Signature B. Sparks					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

10+



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41274

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ROSALIE CRON

2. Date of Death  
Month Day Year  
December 26, 19983. Time of Death  
11:11 AM

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

103-28-7122

8. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

64 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Aug. 29, 1934

9. Birthplace (State or Foreign Country)

Belgium

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Chevy Chase

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5517 Trent Street

10f. Zip Code

20815

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2 Years

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Administrator

16b. Kind of Business/Industry

American

Psychological Assc.

17. Father's Name (First, Middle, Last)

Samuel Heilpern

18. Mother's Name (First, Middle, Maiden Surname)

Dora Halper

19a. Informant's Name/Relationship (Type, Print)

Theodore Cron, Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5517 Trent Street, Chevy Chase, Maryland 20815

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Mount Lebanon Cemetery

Date

12/28/1998

20c. Location - City or Town, State

Adelphi, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

IVES PEARSON FUNERAL HOMES

2847 WILSON BLVD., ARLINGTON, VIRGINIA 22201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

Due to (or as a consequence of):

myocardial infarction

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Due to (or as a consequence of):

Atherosclerosis

Due to (or as a consequence of):

Hypertension

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Deathseveral  
minutes

years

years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending  
Investigation6 ☐ Could not be  
determined

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)2 ☒ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William Swann, M.D., 8600 Old Georgetown Road, Bethesda, Maryland 20814

31. Date filed (Month, Day, Year)

DEC 30 1998

32. Registrar's Signature

Beverly S. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41275

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Gloria J Culver</b>				2. Date of Death Month <b>Dec</b> Day <b>26</b> Year <b>1998</b>		3. Time of Death <b>1250</b>		
	4a. Facility Name (If not institution, give street and number) <b>Montgomery General Hosp</b>				4b. City, Town, or Location of Death <b>Olney</b>		4c. County of Death <b>Montgomery</b>		
Funeral Director	5. Social Security Number <b>215-62-6601</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (in yrs. last birthday) <b>44</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>May 13 1954</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent								
10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Silver Spring</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>913 Ednor Road</b>				10f. Zip Code <b>20905</b>		10g. Citizen of What Country? <b>United States</b>			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>0</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Librarian Assistant</b>			16b. Kind of Business/Industry <b>County Library</b>		
17. Father's Name (First, Middle, Last) <b>Alfred Peter Bayne</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Ruth Minnick</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Kenneth Wayne Culver/Husband</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>913 Ednor Road, Silver Spring, Maryland 20905</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Parklawn Cemetery</b>		Data <b>12/30/98</b>		20c. Location - City or Town, State <b>Rockville, Maryland</b>		
21. Signature of Funeral Service Licensee <b>Muriel H. Barber</b>					22. Name and Address of Facility <b>Muriel H. Barber Funeral Home P.O. Box 5038, Laytonsville, Maryland 20882</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  a. <b>cardiac arrhythmia</b> Due to (or as a consequence of): b. <b>pulmonary insufficiency</b> Due to (or as a consequence of): c. <b>desipramine overdose</b> Due to (or as a consequence of): d.  Approximate Interval Between Onset and Death <b>DATE</b>									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown									
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Don B. Brecher MD</b>		29c. License number <b>D00428</b>		29d. Date signed (Month, Day, Year) <b>Dec 26 1998</b>			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>IRA N. BRECHER, MD DME 2101 Medical Park Dr Silver Spring MD 20902</b>									
31. Date filed (Month, Day, Year) <b>DEC 29 1998</b>				32. Registrar's Signature <b>Denise B. Sparks</b>					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural," or item 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41276

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Joseph Cupp</b>				2. Date of Death Month <b>Dec</b> Day <b>22</b> Year <b>1998</b>		3. Time of Death <b>01:24 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Holy Cross Hospital</b>				4b. City, Town, or Location of Death <b>Silver Spring</b>		4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>218-94-3906</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>33</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Nov. 12, 1965</b>	
	9. Birthplace (State or Foreign Country) <b>Virginia</b>		10a. State <b>MD</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Kensington</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>1-520 Wheatley Street</b>		10f. Zip Code <b>20895</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Automotive Technician</b>		16b. Kind of Business/Industry <b>Euro Motor Cars</b>				
17. Father's Name (First, Middle, Last) <b>Joseph F. Cupp</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Irene Connors</b>		19a. Informant's Name/Relationship (Type, Print) <b>Theresa G. Cupp - Wife</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>13 Grant Ave. Takoma Park, MD 20912</b>		
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Balt. - Wash. Crematory</b>		20c. Location - City or Town, State <b>Laurel, Maryland</b>		20d. Date <b>12/28/98</b>		
21. Signature of Funeral Service Licensee <b>Joseph M. Peters</b>		22. Name and Address of Facility <b>Joseph Gawler's Sons</b> <b>5130 WI Ave. NW Washington, D. C. 20016</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>a. ASTHMA</b> Due to (or as a consequence of): <b>b. CORONARY ARTERY DISEASE</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>		Approximate Interval Between Onset and Death <b>YEARS</b>		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		
28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>M. Snow M.D.</b>		29c. License number <b>D11329</b>		
29d. Date signed (Month, Day, Year) <b>Dec 22 1998</b>		30. Name and address of person who completed cause of death (item 23a) (Type, Print) <b>MARGARET T. SNOW MD 9013 Flower Ave Silver Spring MD 20901</b>		31. Date filed (Month, Day, Year) <b>DEC 28 1998</b>		32. Registrar's Signature <b>Geneva B. Sparks</b>		

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 41277

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

WILLIAM T. CUMBERLAND, II

2. Date of Death

December 25, 1998 4:30 AM

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Shady Grove Adventist Hospital

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

5. Social Security Number

577-34-2469

6. Sex

1 ☒ M 2 ☐ F

7. Age (in yrs. last birthday)

70

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jan 22, 1928

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

MD

10b. County

Howard

10c. City, Town or Location

Woodbine

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

16391 A.E. Mullinix Road

10f. Zip Code

21797

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Plumbing Contractor

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Bo Cumberland

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Newby

19a. Informant's Name/Relationship (Type, Print)

Mrs. Charlene S. Cumberland (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

16391 A.E. Mullinix Road Woodbine, MD 21797

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Crestlawn Memorial Garden 12/31 Marriottsville, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Brian A. Haight

22. Name and Address of Facility

HAIGHT FUNERAL HOME & CHAPEL (Box 195)  
Sykesville, MD 21784 (410)-795-1400

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

METASTATIC NON-SMALL CELL LUNG CANCER

Approximate Interval Between Onset and Death

5 MONTHS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 8 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

James A. Brown, MD

29c. License number

D07285

29d. Date signed (Month, Day, Year)

December 26, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JAMES A. BROWN MD 9707 MEDICAL CENTER DRIVE, ROCKVILLE, MARYLAND

31. Date filed (Month, Day, Year)

DEC 30 1998

32. Registrar's Signature

Denise B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 41278

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last) Catherine Cecelia Coxe  
2. Date of Death Month Day Year December 27, 1998  
3. Time of Death 0306 hrs

Funeral  
Director

4a. Facility Name (If not institution, give street and number) Union Hospital of Cecil County  
4b. City, Town, or Location of Death Elkton  
4c. County of Death Cecil

5. Social Security Number 219-10-3233  
6. Sex ☒ M ☐ F  
7. Age (In yrs. last birthday) 80 Yrs.  
8. Date of Birth (Month, Day, Year) September 8, 1918  
9. Birthplace (State or Foreign Country) Maryland

Usual Residence of Decedent  
10a. State Maryland  
10b. County Cecil  
10c. City, Town or Location Cecilton  
10d. Inside City Limits ☒ Yes ☐ No

10e. Street and Number 136 South Bohemia Avenue  
10f. Zip Code 21913  
10g. Citizen of What Country? United States

11. Marital Status  
☐ Never Married ☐ Married  
☒ Widowed ☐ Divorced  
12. Was Decedent Ever in U.S. Armed Forces?  
☐ Yes ☒ No  
If Yes, Give Year or Dates:  
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
☐ Yes ☒ No Specify:  
14. Race - American Indian, Black, White, etc.  
Specify: White

15. Decedent's Education (Specify only highest grade completed)  
Elementary/Secondary (0-12) 11 College (1-4 or 5+)  
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Food Service ( School System )  
16b. Kind of Business/Industry Board of Education

17. Father's Name (First, Middle, Last) Marion Earl Pearce Sr.  
18. Mother's Name (First, Middle, Maiden Surname) Leona Yates

19a. Informant's Name/Relationship (Type, Print) Etta Coxe Jackson - Daughter  
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4025 Maonor House Dr., N.E. Marietta, Georgia 30062

20a. Method of Disposition  
☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)  
20b. Place of Disposition (Name of cemetery, crematory or other place) Chester Cemetery  
Date December 30, 1998  
20c. Location - City or Town, State Chestertown, Maryland

21. Signature of Funeral Service Licensee William L. King, Jr. M-00937  
22. Name and Address of Facility 226 East Main Street, Cecilton, Maryland 21913

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  
Immediate Cause (Final disease or condition resulting in death) a. Adult Respiratory Distress Syndrome  
Due to (or as a consequence of):  
b. Viral pneumonia  
Due to (or as a consequence of):  
c. COPD  
Due to (or as a consequence of):  
d. cigarette smoking  
Approximate Interval Between Onset and Death Days  
Weeks  
Years  
Years  
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  
complete Heart Block  
Acute Renal Failure

23b. Did tobacco use contribute to the cause of death?  
☒ Yes ☐ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?  
☐ Yes ☐ No  
24b. Were autopsy findings available prior to completion of cause of death?  
☐ Yes ☐ No

25. Was case referred to medical examiner?  
☐ Yes ☐ No  
26. Place of Death (Check only one)  
Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA  
Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death  
☐ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide  
28a. Date of Injury (Month, Day Year)  
28b. Time of Injury M  
28c. Injury at Work? ☐ Yes ☐ No  
28d. Describe how injury occurred  
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)  
☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier  
29c. License number A30291  
29d. Date signed (Month, Day, Year) 12/29/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) DEC 31 1998  
32. Registrar's Signature

Baltimore, Maryland 21215-0020  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41279

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Earl Price Cronshaw</b>				2. Date of Death Month <b>December</b> Day <b>16</b> , Year <b>1998</b>		3. Time of Death <b>3:23 p.m.</b>	
4a. Facility Name (If not institution, give street and number) <b>Corsica Hills Nursing Home</b>				4b. City, Town, or Location of Death <b>Centreville</b>		4c. County of Death <b>Queen Annes</b>	
5. Social Security Number <b>217-36-0637</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>85</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>July 19, 1913</b>	
9. Birthplace (State or Foreign Country) <b>Barclay, Maryland</b>							
Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Queen Annes</b>		10c. City, Town or Location <b>Chestertown</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>6408 Church Hill Road</b>				10f. Zip Code <b>21620</b>		10g. Citizen of What Country? <b>United States</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7</b> Collage (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Yard Manager</b>		16b. Kind of Business/Industry <b>Lumber Company</b>	
17. Father's Name (First, Middle, Last) <b>Edward Sylvester Cronshaw</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Katie Price</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Mrs. Dorothy M. Cronshaw/Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6408 Church Hill Road, Chestertown, Maryland 21620</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Sudlersville Cemetery/December 20, 1998 Sudlersville, MD</b>		20c. Location - City or Town, State		20d. Approximate Interval Between Onset and Death	
21. Signature of Funeral Service Licensee <b>Gary B. Fellows</b>				22. Name and Address of Facility <b>Fellows, Helfenbein &amp; Newnam Funeral Home, P.A. P.O. Box 270, Millington, Maryland 21651-0270</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
Immediate Cause (Final disease or condition resulting in death)							
e. <b>CARDIO pulmonary Arrest</b> Due to (or as a consequence of):							
b. <b>Respiratory Failure</b> Due to (or as a consequence of):							
c. <b>Poorly Controlled Hypertension</b> Due to (or as a consequence of):							
d.							
23a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
e. <b>Chronic Atrial Fibrillation, Anticoagulant</b>							
f. <b>Vascular Disease, Multiple Transient</b>							
g. <b>Ischemic Attacks</b>							
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) <b>None</b>		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier <b>G. Sparks M.D.</b>				29c. License number <b>D-23889</b>		29d. Date signed (Month, Day, Year) <b>12/17/98</b>	
30. Name and address of person who completed cause of death (item 23a) (Type, Print) <b>John C. Annabene M.D., 948 Washington Ave, Chestertown MD 21620</b>							
31. Date filed (Month, Day, Year) <b>DEC 18 1998</b>		32. Registrar's Signature <b>G. Sparks</b>					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41280

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

RUBY E. CARROLL

2. Date of Death

Month Day Year  
DEC 26 1998

3. Time of Death

9:26 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

MEMORIAL HOSPITAL

4b. City, Town, or Location of Death

EASTON

4c. County of Death

TALBOT

5. Social Security Number

228-20-3019

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
June 10, 1916

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Talbot

10c. City, Town or Location

Easton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

29291 Hickory Ridge Road

10f. Zip Code

21601

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

3

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Registered Nurse

16b. Kind of Business/Industry

Medical

17. Father's Name (First, Middle, Last)

Badger Green Eastwood

18. Mother's Name (First, Middle, Maiden Surname)

Annie Belle Winn

19a. Informant's Name/Relationship (Type, Print)

Betty E. Carroll / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5850 Cameron Run Terrace #1102, Alexandria, Virginia

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Spring Hill Cemetery/December 30, Easton, Maryland

Date 1998

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

M. E. Newnam MD &amp; FSP

22. Name and Address of Facility

Fellows, Helfenbein & Newnam Funeral Home, P.A.  
200 S. Harrison Street, Easton, Maryland 21601

23a. Pert. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

s. Probable Myocardial Rupture

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 days

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Myocardial Infarction

Due to (or as a consequence of):

c. Coronary Artery Disease.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Abdominal Aortic Aneurysm

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending Investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, term, street, tectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

R. Bruce Helmly MD

29c. License number

053236

29d. Date signed (Month, Day, Year)

12-26-98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

R. Bruce Helmly, MD, 403 Marvel Court, Easton, Maryland 21601

31. Date filed (Month, Day, Year)

DEC 29 1998

32. Registrar's Signature

B. Sparks

State  
RegistrarCARROLL, RUBY  
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41281

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Louis Edward Copper</b>				2. Date of Death Month Day Year <b>DEC 24 1998</b>				3. Time of Death <b>11:56AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>THE MEMORIAL HOSPITAL</b>				4b. City, Town, or Location of Death <b>EASTON</b>				4c. County of Death <b>TALBOT</b>		
Funeral Director	5. Social Security Number <b>217-30-8132</b>		6. Sex <b>1</b> M <b>2</b> F		7. Age (In yrs. last birthday) <b>87</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Feb. 13, 1911</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		
	Usual Residence of Decedent										
10a. State <b>Maryland</b>		10b. County <b>Talbot</b>		10c. City, Town or Location <b>Cordova</b>				10d. Inside City Limits <b>1</b> Yes <b>2</b> No			
10e. Street and Number <b>29810 Brooks Lane</b>				10f. Zip Code <b>21625</b>		10g. Citizen of What Country? <b>USA</b>					
11. Marital Status <b>1</b> Never Married <b>2</b> Married <b>3</b> Widowed <b>4</b> Divorced			12. Was Decedent Ever In U.S. Armed Forces? <b>1</b> Yes <b>2</b> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> Yes <b>2</b> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>0</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Farm Worker</b>			16b. Kind of Business/Industry <b>Farming</b>				
17. Father's Name (First, Middle, Last) <b>Louis Edward Copper</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Unknown</b>						
19a. Informant's Name/Relationship (Type, Print) <b>Barbara Brooks Osolin, Caretaker</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>12121 Church Ln., Cordova, Maryland 21625</b>						
20a. Method of Disposition <b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State <b>4</b> Donation <b>5</b> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Paradise Cemetery</b>		20c. Location - City or Town, State <b>12/30/98 Trappe, Maryland</b>					
21. Signature of Funeral Service Licensee <b>John A. Prince</b>				22. Name and Address of Facility <b>Bennie Smith Funeral Home P.O. Box 1687, Easton, Maryland 21601</b>							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Probable Gastrointestinal Bleed</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>										Approximate Interval Between Onset and Death <b>~12 hr</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown			
								24a. Was an autopsy performed? <b>1</b> Yes <b>2</b> No			
								24b. Were autopsy findings available prior to completion of cause of death? <b>1</b> Yes <b>2</b> No			
25. Was case referred to medical examiner? <b>1</b> Yes <b>2</b> No				28. Place of Death (Check only one) Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify)							
27. Manner of Death <b>1</b> Nature <b>2</b> Accident <b>3</b> Suicide <b>4</b> Homicide <b>5</b> Pending Investigation <b>6</b> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <b>1</b> Yes <b>2</b> No			
				28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <b>1</b> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <b>2</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. Signature and title of certifier <b>Dr. [Signature]</b>				29c. License number <b>D 52856</b>				29d. Date signed (Month/Day, Year) <b>12/24/98</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Cynthia Rubio, MD, 219 S. Washinton Street, Easton, Maryland 21601</b>											
31. Date filed (Month, Day, Year) <b>DEC 28 1998</b>				32. Registrar's Signature <b>[Signature]</b>							

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

COPPER, LOUIS

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 4 1282

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) Emma Smith Collier				2. Date of Death Month Day Year December 20, 1998		3. Time of Death 5:10am	
4a. Facility Name (If not institution, give street and number) Corsica Hills - Genesis Eldercare				4b. City, Town, or Location of Death Centreville		4c. County of Death Queen Anne's	
5. Social Security Number 215-20-4434		6. Sex 1 <input type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 89 Yrs.		8. Date of Birth (Month, Day, Year) March 15, 1910	
9. Birthplace (State or Foreign Country) Maryland							
Usual Residence of Decedent							
10a. State MD		10b. County Queen Anne's		10c. City, Town or Location Barclay		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 100 Mapel Ave.				10f. Zip Code 21607		10g. Citizen of What Country? U.S.A.	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7grade College (1-4 or 5+) :				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Self-Homemaker	
17. Father's Name (First, Middle, Last) Charles Smith				18. Mother's Name (First, Middle, Maiden Surname) Fannie Sparks			
19a. Informant's Name/Relationship (Type, Print) Faye Lister/niece-in-law				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2307 4-H Park Road Centreville, MD. 21617			
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Chesterfield Cemetery		Date 12/22/98		20c. Location - City or Town, State Centreville, MD.	
21. Signature of Funeral Service Licensee <i>Thomas K. Helfenbein</i>				22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 408 South Liberty St. Centreville, MD. 21617			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. CHF Due to (or as a consequence of): HTN b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last							
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cerebrovascular accident							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				28. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier <i>Gary J. Spruill</i>				29c. License number D32036		29d. Date signed (Month, Day, Year) 12/21/98	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gary J. Spruill 2108 D. Dorch Drive Choke, MD 21619							
31. Date filed (Month, Day, Year) DEC 22 1998				32. Registrar's Signature <i>B. Sparks</i>			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41283

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Sara Catherine Campbell				2. Date of Death Month Day Year Dec. 11, 1998		3. Time of Death 9:00 AM	
	4e. Facility Name (If not institution, give street and number) 717 Dixon Drive				4b. City, Town, or Location of Death Stevensville		4c. County of Death Queen Anne's	
Funeral Director	5. Social Security Number 217-01-5555		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 77 Yrs.		8. Date of Birth (Month, Day, Year) Dec. 25, 1920	
	9. Birthplace (State or Foreign Country) D.C.		10e. State MD		10b. County Queen Anne's		10c. City, Town or Location Stevensville	
To Be Completed by Funeral Director	Usual Residence of Decedent				10f. Zip Code 21666		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Microfilm Operator		16b. Kind of Business/Industry Westinghouse			
	17. Father's Name (First, Middle, Last) Frederick C. Parker				18. Mother's Name (First, Middle, Maiden Surname) Alice Abel			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Carol L. Thomas Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 717 Dixon Drive, Stevensville, MD 21666			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Stevensville Cemetery		20c. Date Dec. 21, 1998		20d. Location - City or Town, State Stevensville, MD	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensed 				22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home P.A. 106 Shamrock Road, Chester, MD 21619			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CONGESTIVE HEART FAILURE Due to (or as a consequence of): b. CORONARY ARTERY DISEASE Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death 2 yrs. 75 yrs.			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
							24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred						28e. Location (Street and Number or Rural Route Number, City or Town, State)	
	28f. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						29b. Signature and title of certifier 	
	29c. License number D 41587						29d. Date signed (Month, Day, Year) 12/14/98	
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Helen A. Noble, 122 Speer Road, Suite 5, Chestertown, MD 21620							
	31. Date filed (Month, Day, Year) DEC 15 1998				32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 41284

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Franklyn

Denise

2. Date of Death

December 20 1998

3. Time of Death

2058

4a. Facility Name (If not institution, give street and number)

The Johns Hopkins Hospital

Baltimore

4b. City, Town, or Location of Death

4c. County of Death

Baltimore City

Funeral  
Director

5. Social Security Number

241-56-1990

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

59

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Feb 4, 1939

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Pennsylvania

10b. County

Lucerne

10c. City, Town or Location

Drums

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

105 Covey Ln

10f. Zip Code

18222

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Industrial Engineer

16b. Kind of Business/Industry

Engineering

17. Father's Name (First, Middle, Last)

Warren Denise

18. Mother's Name (First, Middle, Maiden Surname)

Lorena Patterson

19a. Informant's Name/Relationship (Type, Print)

Billie A. Denise/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

105 Covey Ln, Drums, PA 18222

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Ft. Lincoln Crematory

Date

Dec 24

20c. Location - City or Town, State

Brentwood, MD

21. Signature of Funeral Service Licensee

Alany J. Donnell

22. Name and Address of Facility

Hines-Rinaldi Funeral Home

11800 New Hampshire Ave, Silver Spring, MD 20904

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Gastrointestinal Bleeding

Due to (or as a consequence of):

b. Pancreatic cancer

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

1 Week

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)29. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Alfred F Faust, M.D.

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

December 20 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Alfred F. Faust 600 North Wolfe Street, Baltimore MD 21287

31. Date filed (Month, Day, Year)

DEC 29 1998

32. Registrar's Signature

Geneva B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

24



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41285

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Peter DiGiulian</b>				2. Date of Death Month <b>December</b> Day <b>24</b> , Year <b>1998</b>		3. Time of Death <b>2:50pm</b>		
	4a. Facility Name (If not institution, give street and number) <b>Wilson Health Care Center</b>				4b. City, Town, or Location of Death <b>Gaithersburg</b>		4c. County of Death <b>Montgomery</b>		
Funeral Director	5. Social Security Number <b>578-05-8100</b>		8. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>85</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>June 11, 1913</b>	9. Birthplace (State or Foreign Country) <b>Washington, DC</b>	
	Usual Residence of Decedent								
10a. State <b>DC</b>		10b. County		10c. City, Town or Location <b>Washington</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>3336 Tennyson Street</b>				10f. Zip Code <b>20015</b>		10g. Citizen of What Country? <b>United States</b>			
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Tile Setter</b>			16b. Kind of Business/Industry <b>Tile</b>		
17. Father's Name (First, Middle, Last) <b>Joseph DiGiulian</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Stefania Castellini</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Corinna DiGiulian (Sister)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3336 Tennyson Street, NW, Washington, DC 20015</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>St. Mary's Cemetery</b>		Date <b>12/29/98</b>		20c. Location - City or Town, State <b>Washington, DC</b>		
21. Signature of Funeral Service Licensee <i>Robert A. DeVol</i>				22. Name and Address of Facility DeVol Funeral Home <b>10 East Deer Park Drive Gaithersburg, MD 20877</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>congestive heart failure</b> Due to (or as a consequence of):  b. <b>valvular heart disease</b> Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death  <b>years</b>  <b>years</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <b>mental retardation</b> <b>atrial fibrillation</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								29b. Signature and title of certifier <i>John R. Melnick MD</i>	
29c. License number <b>D19294</b>								29d. Date signed (Month, Day, Year) <b>December 24, 1998</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>JOHN R. MELNICK 911 RUSSEL AVE GAITHERSBURG, MD 20879</b>								31. Date filed (Month, Day, Year) <b>DEC 28 1998</b>	
32. Registrar's Signature <i>Benita B. Sparks</i>									

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 41286

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>TROY A. DUGGER JR.</b>				2. Date of Death Month Day Year <b>DEC. 19, 1998</b>		3. Time of Death <b>0340 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>PRINCE GEORGES HOSPITAL CENTER</b>				4b. City, Town, or Location of Death <b>CHEVERLY</b>		4c. County of Death <b>PRINCE GEORGES</b>		
Funeral Director	5. Social Security Number <b>579 04 6345</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>19</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>AUG 4 1979</b>		
	9. Birthplace (State or Foreign Country) <b>WASH. D.C.</b>		10a. State <b>MD.</b>		10b. County <b>P.G.</b>		10c. City, Town or Location <b>HYATTSVILLE</b>		
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>717 CHILLUM ROAD #201</b>		10f. Zip Code <b>20783</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (14 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>CABLE TECHNICIAN</b>		16b. Kind of Business/Industry <b>PVT.</b>		17. Father's Name (First, Middle, Last) <b>TROY DUGGER SR.</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>LORRETA JOHNSON</b>	
19a. Informant's Name/Relationship (Type, Print) <b>LORRETA JOHNSON/MOTHER</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>717 CHILLUM RD. #201 HYATTSVILLE, MD. 20783</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>GLENWOOD CEM.</b>		20c. Location - City or Town, State <b>WASHINGTON, D.C.</b>	
21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility <b>WATSON F. H. INC. 3435 14th ST., N.W. 20010</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>a. Multiple Stab Wounds</b>		Approximate Interval Between Onset and Death			
Immediate Cause (Final disease or condition resulting in death)		Due to (or as a consequence of):		Due to (or as a consequence of):		Due to (or as a consequence of):		Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>12/19/98</b>		28b. Time of Injury Found <b>0245 M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>Subject Stabbed</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>Parking lot - Found ; Bladensburg Rd + V St, NE, Washington, DC</b>		29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>[Signature]</i> M.D.	
29c. License number <b>O.C.M.E</b>		29d. Date signed (Month, Day, Year) <b>DEC. 19, 1998</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201</b>		31. Data filed (Month, Day, Year) <b>DEC 29 1998</b>		32. Registrar's Signature <i>[Signature]</i>	

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

3

pic 52

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41287

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Carolyn J. DuPree

2. Date of Death

Day Year  
12/25/1998

3. Time of Death

12:10 AM

4a. Facility Name (If not institution, give street and number)

SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

5. Social Security Number

566-50-6549

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
9/06/1911

9. Birthplace (State or Foreign Country)

GEORGIA

Usual Residence of Decedent

10a. State

MD

10b. County

MONTGOMERY

10c. City, Town or Location

GAIHERSBURG

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

109 ORCHARD HILLS DRIVE

10f. Zip Code

20878

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SECRETARY

16b. Kind of Business/Industry

PUBLISHING

17. Father's Name (First, Middle, Last)

SMITH JENNINGS, SR.

18. Mother's Name (First, Middle, Maiden Surname)

ANNIE REID

19a. Informant's Name/Relationship (Type, Print)

DENISE R. DUPREE-JONES

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

109 ORCHARD HILLS DRIVE GAIHERSBURG MD 20878

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

FORT LINCOLN CREMATORY

Date

12/28/98 BRENTWOOD MARYLAND

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

HINES-RINALDI FUNERAL HOME, INC.

11800 NEW HAMPSHIRE AVE. SILVER SPRING MD 20904

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. RUPTURE OF MYOCARDIUM

Due to (or as a consequence of):

MINUTES

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. ACUTE MYOCARDIAL INFARCTION

Due to (or as a consequence of):

MINUTES

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Deborah Sherr: 11 m.o 9901 medical Center Dr. Rockville, md. 20850

31. Date filed (Month, Day, Year)

DEC 29 1998

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41288

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Alisa Diaz</b>				2. Date of Death Month Day Year <b>December 24, 1998</b>		3. Time of Death <b>07:35 a.m.</b>	
	4a. Facility Name (If not institution, give street and number) <b>Washington Adventist Hospital</b>				4b. City, Town, or Location of Death <b>Takoma Park</b>		4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>None</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (in yrs. last birthday) Yrs. Months Days	8. Date of Birth (Month, Day, Year) <b>10 Dec. 24, 1998</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent				10. City, Town or Location <b>Silver Spring</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10a. State <b>MD</b>		10b. County <b>Montgomery</b>		10f. Zip Code <b>20904</b>		10g. Citizen of What Country? <b>USA</b>		
10e. Street and Number <b>11447 Lockwood Drive, #104</b>		11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>N/A</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>N/A</b>		16b. Kind of Business/Industry <b>N/A</b>		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
17. Father's Name (First, Middle, Last) <b>Angel Milciades Diaz</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Shelene Marie Martin</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Suseela Drumheller, Birth Regis.</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7600 Carroll Ave., Takoma Park, MD 20912</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Ft. Lincoln Cemetery</b>		20c. Location - City or Town, State <b>12/29/98 Brentwood, Maryland</b>		21. Signature of Funeral Service Licensee <b>Curtis E. Day</b>		
22. Name and Address of Facility <b>DeVol Funeral Home</b>		22. Name and Address of Facility <b>10 East Deer Park Drive</b>		22. Name and Address of Facility <b>Gaithersburg, MD 20877</b>		23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		28d. Describe how injury occurred		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		
29b. Signature and title of certifier <b>L. Ferguson MD</b>		29c. License number <b>20052750</b>		29d. Date signed (Month, Day, Year) <b>12/24/98</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Lincoln Ferguson, M.D., WAH, 7600 Carroll Ave., Takoma Park, MD 20912</b>		
31. Date filed (Month, Day, Year) <b>DEC 28 1998</b>		32. Registrar's Signature <b>B. Sparks</b>						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

Handwritten notes, mostly illegible due to fading. Some words like "The", "and", "of" are visible.

Further down the page, more handwritten text is visible, including the word "The" and some numbers.

At the bottom of the page, there are some numbers and possibly a date, such as "10/10/18".



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Amend #5, 1/4/99, BMW, Montg. Co.  
Amend #10e, 1/4/99, BMW, Montg. Co.

08 41289

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

HERBERT

DIAMOND

2. Date of Death  
Month Day Year  
DECEMBER 23, 19983. Time of Death  
3:00 PMFuneral  
Director

4a. Facility Name (If not institution, give street and number)

1111 UNIVERSITY BLVD WEST #116

4b. City, Town, or Location of Death

SILVER SPRING

4c. County of Death

MONTGOMERY

5. Social Security Number

055-05-0539  
~~050-55-0539~~

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
07.09.1920

9. Birthplace (State or Foreign Country)

NEW YORK

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

MONTGOMERY

10c. City, Town or Location

SILVER SPRING

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1111 UNIVERSITY BLVD. WEST #116

10f. Zip Code

20902

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

PRINTER

16b. Kind of Business/Industry

SELF EMPLOYED

17. Father's Name (First, Middle, Last)

FISCHEL DIAMOND

18. Mother's Name (First, Middle, Maiden Surname)

FRIEDA KALISHMAN

19a. Informant's Name/Relationship (Type, Print)

JEANETTE DIAMOND/WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1111 UNIVERSITY BLVD W #116, SILVER SPRING MD 20902

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MT. LEBANON CEMETERY

Date

12.24.98 ADELPHI, MARYLAND

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

EDWARD SAGEL FUNERAL DIRECTION, INC.

1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC RENAL CELL CARCINOMA

ONE YEAR

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 22775

29d. Date signed (Month, Day, Year)

DECEMBER 24, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. FREDERICK G. BARR, 2101 MEDICAL PARK DRIVE, #210, SILVER SPRING, MD 20902-4000

31. Date filed (Month, Day, Year)

DEC 28 1998

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural" or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

10. 10. 1944

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Vernon C

Devan

2. Date of Death

Month Day Year  
December 29, 1998

3. Time of Death  
2:43 am

4a. Facility Name (If not institution, give street and number)

Shady Grove Adventist Hospital

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

198-18-6131

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

74 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Sept. 10, 1924

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Derwood

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

17808 Vinyard Lane

10f. Zip Code

20855

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: 1944-1974

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (14 or 5+)

5+

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Vice President Computer Corp.

16b. Kind of Business/Industry

Computer

17. Father's Name (First, Middle, Last)

Vernon Alger Devan

18. Mother's Name (First, Middle, Maiden Surname)

Henrietta McClellan

19a. Informant's Name/Relationship (Type, Print)

Constance M. Devan (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

17808 Vinyard Lane, Derwood, MD 20855

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arlington National Cemetery 1/6/99 Arlington, Virginia

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

*Robert A. DeVos*

22. Name and Address of Facility

DeVol Funeral Home  
10 East Deer Park Drive  
Gaithersburg, MD 20877

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial Infarction

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

8 hours

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Lipidemia, hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*Dennis Friedman*

29c. License number

24971

29d. Date signed (Month, Day, Year)

December 29 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dennis Friedman 15225 Shady Grove Rd., Rockville

31. Date filed (Month, Day, Year)

DEC 31 1998

32. Registrar's Signature

*B. Sparks*

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 41291

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ruth Anna Radcliffe Dawkins				2. Date of Death Month Day Year December 19, 1998				3. Time of Death 8:00p.m.	
	4a. Facility Name (If not Institution, give street and number) Kent & Queen Anne's Hospital				4b. City, Town, or Location of Death Chestertown				4c. County of Death Kent	
Funeral Director	5. Social Security Number 218-10-5873		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 70 Yrs.		8. Date of Birth (Month, Day, Year) March 3, 1928		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent				10a. State Maryland		10b. County Caroline		10c. City, Town or Location Henderson	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				10e. Street and Number 16840 Henderson Road		10f. Zip Code 21640		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Proofreader				16b. Kind of Business/Industry Printing	
	17. Father's Name (First, Middle, Last) Rufus Radcliffe				18. Mother's Name (First, Middle, Maiden Surname) Evelyn Lewis					
	19a. Informant's Name/Relationship (Type, Print) Thomas M. Dawkins/Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16840 Henderson Road, Henderson, MD 21640					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Chesterfield Cemetery		Date 12/22/98		20c. Location - City or Town, State Centreville, MD			
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility Dellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, MD 21620					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. RESPIRATORY ACIDOSIS Due to (or as a consequence of): b. CHRONIC OBSTRUCTIVE PULMONARY DISEASE Due to (or as a consequence of): c. Due to (or as a consequence of): d.				Approximate Interval Between Onset and Death 3 days >5 yrs.					
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PNEUMONIA				23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accidental 3 <input type="checkbox"/> Suicidal 4 <input type="checkbox"/> Homicidal 5 <input type="checkbox"/> Pending Investigation 8 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>[Signature]</i>				29c. License number D41587		29d. Date signed (Month, Day, Year) 12/21/98		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Helen A. Noble 122 Speer Road, Suite 5, Chestertown, Maryland 21620										
31. Date filed (Month, Day, Year) DEC 21 1998		32. Registrar's Signature <i>[Signature]</i>								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>SARA EISNER</b>				2. Date of Death Month <b>DECEMBER</b> Day <b>27</b> Year <b>1998</b>		3. Time of Death <b>5:14PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>5225 POOKS HILL ROAD #604S</b>				4b. City, Town, or Location of Death <b>BETHESDA</b>		4c. County of Death <b>MONTGOMERY</b>	
Funeral Director	5. Social Security Number <b>578 46 7323</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>92</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>OCTOBER 12 1906</b>	9. Birthplace (State or Foreign Country) <b>RUSSIA</b>
	Usual Residence of Decedent							
10a. State <b>MARYLAND</b>		10b. County <b>MONTGOMERY</b>		10c. City, Town or Location <b>BETHESDA</b>		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number <b>5225 POOKS HILL ROAD #604S</b>				10f. Zip Code <b>20814</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No: If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOMEMAKER</b>		16b. Kind of Business/Industry <b>OWN HOME</b>		
17. Father's Name (First, Middle, Last) <b>SAMUEL PLASKY</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>CELIA KRIEGER</b>				
19a. Informant's Name/Relationship (Type, Print) <b>GILBERT M. EISNER/SON</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7612 ROSSDHU COURT CHEVY CHASE, MARYLAND 20815</b>				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>B'NAT ISRAEL CEMETERY</b>		Date <b>12/29/98</b>		20c. Location - City or Town, State <b>OXEN HILL, MARYLAND</b>		
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <b>DANZANSKY GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE ROCKVILLE, MARYLAND 20852</b>				
23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <b>Pneumonia</b> Due to (or as a consequence of): b. <b>Cerebral Vascular Medial</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death <b>24 hours</b> <b>72 hours</b>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Myocardial Ischemic Disease</b> <b>Severe Peripheral Vascular Disease</b> <b>Tracheal Stenosis - tracheostomy tube</b>								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Attending Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <i>[Signature]</i>				29c. License number <b>D13818</b>		29d. Date signed (Month, Day, Year) <b>12/29/1998</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>GARY FISHER, M.D. 5530 WISCONSIN AVENUE #730 BETHESDA, MARYLAND 20815</b>								
31. Date filed (Month, Day, Year) <b>DEC 31 1998</b>				32. Registrar's Signature <i>[Signature]</i>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural" or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41293

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Denton Webber Elliott

2. Date of Death  
Month Day Year  
December 25, 1998

3. Time of Death  
6:20pm

4a. Facility Name (If not institution, give street and number)

Wilson Health Care Center

4b. City, Town, or Location of Death

Gaithersburg

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

269-10-2344

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

6. Date of Birth (Month, Day, Year)

Feb. 18, 1914

9. Birthplace (State or Foreign Country)

Ohio

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

415 Russell Avenue #115

10f. Zip Code

20877

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Chemist

16b. Kind of Business/Industry

Chemistry

17. Father's Name (First, Middle, Last)

Herschell Elliott

16. Mother's Name (First, Middle, Maiden Surname)

Bessie Webber

19a. Informant's Name/Relationship (Type, Print)

Louise B. Elliott (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

415 Russell Avenue #115, Gaithersburg, MD 20877

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory 12/26/98

Date

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

*Robert G. DeVol*

22. Name and Address of Facility

DeVol Funeral Home  
10 East Deer Park Drive  
Gaithersburg, MD 20877

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

*Congestive heart failure*

Due to (or as a consequence of):

*Arteriosclerotic cardiovascular*

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

*Arteriosclerotic cardiovascular*

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*Recent acute myocardial infarction*  
*Anemia of chronic disease*  
*Multifactorial dementia*  
*Pleural effusion*

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☒ Nursing Home

5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

26d. Describe how injury occurred

26e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

*H. Robert Birschbach*

29c. License number

504115

29d. Date signed (Month, Day, Year)

December 25, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

H. Robert Birschbach, MD, 6320 Democracy Blvd., Bethesda, MD 20817

State  
Registrar

31. Date filed (Month, Day, Year)

DEC 28 1998

32. Registrar's Signature

*B. Sparks*

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

08 41294

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JUDITH ENGEL</b>				2. Date of Death Month Day Year <b>DEC 25 1998</b>		3. Time of Death <b>10:20AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>8208 RESERVIOR RD</b>				4b. City, Town, or Location of Death <b>FULTON</b>		4c. County of Death <b>HOWARD</b>	
Funeral Director	5. Social Security Number <b>126 34 2177</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>63</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>SEPT 2, 1935</b>	9. Birthplace (State or Foreign Country) <b>HUNGARY</b>
	Usual Residence of Decedent							
10a. State <b>MD</b>		10b. County <b>HOWARD</b>		10c. City, Town or Location <b>FULTON</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>8208 RESERVIOR RD</b>				10f. Zip Code <b>20759</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>SECRETARY</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>SECRETARY</b>			16b. Kind of Business/Industry <b>SELF EMPLOYED</b>	
17. Father's Name (First, Middle, Last) <b>LASZLO GRUNWALD</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>PAULINE SCHWARTZ</b>				
19a. Informant's Name/Relationship (Type, Print) <b>JOEL TIBOR ENGEL HUSBAND</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8208 RESERVIOR RD, FULTON, MD 20759</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify):		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MT. LEBANON CEMETERY</b>		Date <b>12-27-98</b>		20c. Location - City or Town, State <b>ADELPHI, MD</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC</b> <b>1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852</b>				
23a. Part I. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. METASTATIC LUNG CANCER</b> Due to (or as a consequence of):  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <b>Martin C. Sharkey MD</b>				29c. License number <b>208944</b>		29d. Date signed (Month, Day, Year) <b>12/26/98</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MARTIA C. SHARKEY, MD</b>				<b>3720 FARRAGUT AVE.</b> <b>KENSINGTON, MD - 20895</b>				
31. Date filed (Month, Day, Year) <b>DEC 29 1998</b>				32. Registrar's Signature <b>Beverly B. Sparks</b>				

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 41295

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Earl Weech Farr Jr.</b>				2. Date of Death Month Day Year <b>Dec. 24, 1998</b>				3. Time of Death <b>4:02PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>Maplewood Park Place</b>				4b. City, Town, or Location of Death <b>Bethesda</b>				4c. County of Death <b>Montgomery</b>		
Funeral Director	5. Social Security Number <b>211-47-4911</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>82</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Jan. 28, 1916</b>		9. Birthplace (State or Foreign Country) <b>Washington, DC</b>		
	Usual Residence of Decedent										
10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Bethesda</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10e. Street and Number <b>9707 Old Georgetown Road</b>				10f. Zip Code <b>20814</b>				10g. Citizen of What Country? <b>U.S.A</b>			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Senior Vice-President</b>				16b. Kind of Business/Industry <b>Frank S. Phillips INC Real Estate</b>			
17. Father's Name (First, Middle, Last) <b>Earl W. Farr Sr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Hammer</b>							
19a. Informant's Name/Relationship (Type, Print) <b>James E. Farr-Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6609 Kennedy Dr., Chevy Chase, MD 20815</b>							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Columbia Gardens</b>		20c. Date <b>12/29/98</b>		20d. Location - City or Town, State <b>Arlington, Virginia</b>			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Joseph Gawler's Sons INC, 5130 Wisconsin Ave. NW Washington, DC 20016</b>							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death	
Immediate Cause (Final disease or condition resulting in death) <b>Urosepsis</b>										<b>48 Hours</b>	
Due to (or as a consequence of): <b>Obstructive Uropathy</b>										<b>2 Months</b>	
Due to (or as a consequence of): <b>Prostate Cancer</b>										<b>Years</b>	
Due to (or as a consequence of):											
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Partial Bowel Obstruction</b>										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier  <b>T. J. MacNamara MD.,</b>				29c. License number <b>D32610</b>		29d. Date signed (Month, Day, Year) <b>Dec. 28, 1998</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>T. J. MacNamara MD., 5602 Shields Dr., Bethesda, MD 20817-3571</b>										31. Date filed (Month, Day, Year) <b>DEC 30 1998</b>	
32. Registrar's Signature 											

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





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State of Maryland / Department of Health and Mental Hygiene 98 41296

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Frances Felt</b>				2. Date of Death Month <b>Dec</b> Day <b>23</b> Year <b>1998</b>		3. Time of Death <b>03:25pm</b>	
	4a. Facility Name (If not institution, give street and number) <b>Holy Cross Hospital</b>				4b. City, Town, or Location of Death <b>Silver Spring</b>		4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>578-26-1302</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>99</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Sept. 18, 1899</b>	
	9. Birthplace (State or Foreign Country) <b>Indiana</b>		10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Silver Spring</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number <b>3321 South Leisure World Blvd., #3C</b>		10f. Zip Code <b>20906</b>	
	10g. Citizen of What Country? <b>United States</b>				11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>				16b. Kind of Business/Industry <b>Own Home</b>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>Frank Brubeck</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mabel Brake</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Thomas E. Felt (son)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Same as 10</b>			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Chesapeake Crematory</b>		20c. Location - City or Town, State <b>12-24-98 Beltsville, Maryland</b>	
	21. Signature of Funeral Service Licensee <b>Alex H. Rapp</b>				22. Name and Address of Facility <b>Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910</b>			
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Pneumonia</b> Due to (or as a consequence of):  Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>						Approximate interval Between Onset and Death <b>1 week</b>	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier <b>Myron L. Levin</b>				29c. License number <b>006674</b>		29d. Date signed (Month, Day, Year) <b>Dec 24, 1998</b>	
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MYRON L. LEVIN MD 2309 Shorefield Rd Silver Spring MD 20902</b>							
	31. Date filed (Month, Day, Year) <b>DEC 28 1998</b>				32. Registrar's Signature <b>B. Sparks</b>			

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41297

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Douglas A. Fields

2. Date of Death

December 18, 1998

3. Time of Death

10:00 A.M.

4a. Facility Name (If not institution, give street and number)

6904 Wells Parkway

4b. City, Town, or Location of Death

University Park

4c. County of Death

Prince Georges

Funeral  
Director

5. Social Security Number

216-12-4561

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

76 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Feb. 28, 1922

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

MD

10b. County

Prince Georges

10c. City, Town or Location

University Park

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6904 Wells Parkway

10f. Zip Code

20782

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1943-45

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Buick Dealer

16b. Kind of Business/Industry

Automobile

17. Father's Name (First, Middle, Last)

Thomas McCoy Fields

18. Mother's Name (First, Middle, Maiden Surname)

Beulah Ann McCallum

19a. Informant's Name/Relationship (Type, Print)

Eleanor H. Fields/ Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6904 Wells Parkway, University Park, MD 20782

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory

Date

Dec 19, 1998

20c. Location - City or Town, State

Alexandria, VA

21. Signature - Funeral Service Licensee

*J. Kevin Gutowski*

22. Name and Address of Facility

Francis J. Collins Funeral Home Inc. 500 University Blvd. West, Silver Spring, MD, 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Cerebrovascular Accident*

Due to (or as a consequence of):

3 yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. *Cardiac Arrhythmia*

Due to (or as a consequence of):

5 yrs

c. *Cardiomyopathy*

Due to (or as a consequence of):

7 yrs

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*Pacemaker Implant**Extensive Pressure Wounds (DECUBITOUS ULCERS)*

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*Gary W. Jones MD*

29c. License number

D30111

29d. Date signed (Month, Day, Year)

Dec 19, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gary W Jones MD 11305 Pitsea Dr Beltsville Md 20705-1257

31. Date filed (Month, Day, Year)

DEC 28 1998

32. Registrar's Signature

*Benita B. Sparks*State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

12+1



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41298

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>KOPEL (KARL) FORSETER</b>					2. Date of Death Month Day Year <b>DECEMBER 27, 1998</b>			3. Time of Death <b>10:15PM</b>			
	4a. Facility Name (If not institution, give street and number) <b>HEBREW HOME</b>					4b. City, Town, or Location of Death <b>ROCKVILLE</b>			4c. County of Death <b>MONTGOMERY</b>			
Funeral Director	5. Social Security Number <b>086-16-0527</b>		6. Sex <b>XX</b> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>87</b> Yrs.		8. Date of Birth Month Day Year <b>JANUARY 5, 1911</b>		9. Birthplace (State or Foreign Country) <b>POLAND</b>			
	Usual Residence of Decedent											
10a. State <b>MD</b>		10b. County <b>MONTGOMERY</b>		10c. City, Town or Location <b>ROCKVILLE</b>				10d. Inside City Limits <b>XX</b> Yes <input type="checkbox"/> No				
10e. Street and Number <b>6417 DANVILLE COURT</b>					10f. Zip Code <b>20852</b>		10g. Citizen of What Country? <b>UNITED STATES</b>					
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <b>XX</b> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WW II</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <b>XX</b> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>PROPRITOR</b>			16b. Kind of Business/Industry <b>CARMENT MANUFACTURING</b>				
17. Father's Name (First, Middle, Last) <b>MOSES FORSETER</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>LENA (UNAVAILABLE)</b>							
19a. Informant's Name/Relationship (Type, Print) <b>MURRAY FORSETER (SON)</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>11 BRAD LANE WHITEPLAINS NY 10605</b>							
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <b>XX</b> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)					20b. Place of Disposition (Name of cemetery, crematory or other place) <b>BETH MOSES CEMETERY</b>		Date <b>12/30/98</b>		20c. Location - City or Town, State <b>PINELAWN, NY</b>			
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility <b>DANZANSKY-GOLDBERG MEMORIAL CHAPEL 1170 ROCKVILLE PIKE ROCKVILLE MD 20852</b>							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>PARKINSONISM-DEMENTIA COMPLEX</b>										Approximate Interval Between Onset and Death		
Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):												
Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last												
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <b>XX</b> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
										24a. Was an autopsy performed? <input type="checkbox"/> Yes <b>XX</b> No		
										24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <b>XX</b> No					26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> Other: <b>XX</b> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined					28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
					28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <b>XX</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
29b. Signature and title of certifier 					29c. License number <b>D18084</b>			29d. Date signed (Month, Day, Year) <b>DECEMBER 28, 1998</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>D.D. PATEL, M.D. 6121 MONTROSE ROAD, ROCKVILLE MD 20852</b>												
31. Date filed (Month, Day, Year) <b>DEC 31 1998</b>					32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "Natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41299

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Rosa May Frank						2. Date of Death Month Day Year December 29, 1998		3. Time of Death 1:05 a.m.	
	4a. Facility Name (If not institution, give street and number) Suburban Hospital						4b. City, Town, or Location of Death Bethesda		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 053-18-9089		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) Yrs. 78		8. Date of Birth (Month, Day, Year) Jan. 11, 1920		9. Birthplace (State or Foreign Country) Washington, DC	
	Usual Residence of Decedent									
10a. State MD		10b. County Montgomery		10c. City, Town or Location Chevy Chase				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 4701 Willard Avenue				10f. Zip Code 20815		10g. Citizen of What Country? U.S.A.				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 1+ College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home			
17. Father's Name (First, Middle, Last) Norman Fischer						18. Mother's Name (First, Middle, Maiden Surname) Agnes May				
19a. Informant's Name/Relationship (Type, Print) Milton Frank Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5801 Edson Lane T-4 Rockville, MD 20852						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Washington Hebrew Congregation Cemetery			20c. Location - City or Town, State 12/31/98 Washington, D.C.				
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Joseph Gawler's Sons, Inc. 5130 Wisconsin Avenue N.W., Washington, D.C. 20016						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)										13 DAYS
Due to (or as a consequence of):										
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last										13 DAYS
Due to (or as a consequence of):										
c. ISCHEMIC CARDIOMYOPATHY										UNKNOWN
Due to (or as a consequence of):										
d. CORONARY HEART DISEASE										UNKNOWN
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier Thomas A. Sinderson, MD				29c. License number 19144		29d. Date signed (Month, Day, Year) DECEMBER 29, 1998				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THOMAS G. SINDERSON, MD. 6410 ROCKLEDGE DRIVE, BETHESDA, Md. 20817										
31. Date filed (Month, Day, Year) DEC 30 1998		32. Registrar's Signature 								

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit notice.

Division of Vital Records, P.O. Box 68760,

State  
Registrar





Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Donnell J Freeman</b>				2. Date of Death Month Day Year <b>DECEMBER 21, 1998</b>		3. Time of Death <b>1435 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>4729 JOHN STREET</b>				4b. City, Town, or Location of Death <b>MORNINGSIDE</b>		4c. County of Death <b>PRINCE GEORGES</b>	
Funeral Director	5. Social Security Number <b>579-74-4464</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>46</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>09-21-1952</b>	
	9. Birthplace (State or Foreign Country) <b>Wash D.C.</b>		10a. State <b>MD</b>		10b. County <b>P.G.</b>		10c. City, Town or Location <b>Suitland</b>	
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>4729 John Street</b>		10f. Zip Code <b>20746</b>		
10g. Citizen of What Country? <b>USA</b>		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year(s) of Service <b>DC Nat Guard</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		
14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Asst Supervisor</b>		16b. Kind of Business/Industry <b>Sidley &amp; Austin Law Firm</b>		
17. Father's Name (First, Middle, Last) <b>Haywood Freeman</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Pauline M. Waldron</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Wanda B Freeman (Wife)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2310 Brooks Dr #101 Suitland, Md 20746</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Wash National Cemetery</b>		20c. Date <b>12/29/98</b>		20d. Location - City or Town, State <b>Suitland Md</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Austin Royster Funeral Home</b> <b>3821 14th St. NW Wash, D.C. 20011</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b.</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 				29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>DECEMBER 22, 1998</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dennis J. Chute, MD 111 Penn Street, Baltimore, Maryland 21201</b>								
31. Date filed (Month, Day, Year) <b>DEC 29 1998</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41301

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>DAVID FUSS</b>				2. Date of Death Month Day Year <b>DECEMBER 23, 1998</b>				3. Time of Death <b>11:55 P.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>MANOR CARE NURSING HOME</b>				4b. City, Town, or Location of Death <b>CHEVY CHASE</b>				4c. County of Death <b>MONTGOMERY</b>	
Funeral Director	5. Social Security Number <b>577-54-8857</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>87</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>AUGUST 5, 1911</b>		9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>	
	Usual Residence of Decedent									
10a. State <b>N/A</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Washington, D.C.</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>5412 31st Street, N.W.</b>				10f. Zip Code <b>20015</b>				10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WWII</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7+</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Attorney</b>				16b. Kind of Business/Industry <b>Law</b>		
17. Father's Name (First, Middle, Last) <b>Jacob Fuss</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Dora Rabinovit</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Martha Fuss</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5412 31st Street, N.W., Washington DC 20015</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gate Of Heaven Cemetery</b>		Date <b>12/28/98</b>		20c. Location - City or Town, State <b>Silver Spring, MD</b>		
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility <b>Joseph Gawler's Sons 5130 Wisconsin Avenue, N.W. Washington, DC 20016</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Alzheimers Disease</b> Due to (or as a consequence of):  Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>3 years</b> Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Cerebral Vascular Accident</b>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
				28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier 					29c. License number <b>D51015</b>			29d. Date signed (Month, Day, Year) <b>December 26, 1998</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>ELLEN PINHOLT, M.D. 5530 WISCONSIN AVENUE, #1045, CHEVY CHASE, MD 20815</b>										
31. Date filed (Month, Day, Year) <b>DEC 28 1998</b>				32. Registrar's Signature 						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41302

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ROBERT K. GINN

2. Date of Death  
Month Day Year  
December 18, 19983. Time of Death  
4:10PM

4a. Facility Name (If not institution, give street and number)

VA MARYLAND HEALTH CARE SYSTEM

4b. City, Town, or Location of Death

PERRY POINT

4c. County of Death

CECIL

Funeral  
Director

5. Social Security Number

137-26-7782

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

61 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Mar. 20, 1937

9. Birthplace (State or Foreign Country)

S. Carolina

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

14105 Gaines Avenue

10f. Zip Code

20853

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☒ Yes ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Microbiologist

16b. Kind of Business/Industry

N.I.H.

17. Father's Name (First, Middle, Last)

Hermna Ginn

18. Mother's Name (First, Middle, Maiden Summa)

Corrine Mixson

19a. Informant's Name/Relationship (Type, Print)

Wilhelmina V. Ginn (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14105 Gaines Ave., Rockville, MD 20853

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate of Heaven Cem.

Date

12/29/98 Silver Spring, MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SNOWDEN FUNERAL HOME, P.A.  
ROCKVILLE, MD 20850

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. PNEUMONIA

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 Day

Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CEREBROVASCULAR ACCIDENT, OLD.

SEIZURE DISORDER.

HYPERTENSION

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☒ Yes ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other:

☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

151094-1

29d. Date signed (Month, Day, Year)

December 18, 1998

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

MELECIA SANTOS, M.D., VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MARYLAND 21902

31. Date filed (Month, Day, Year)

DEC 28 1998

32. Registrar's Signature

State  
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'natural', or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

10





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) <b>HELEN MOORE GINSBURG</b>				2. Date of Death Month <b>DECEMBER</b> Day <b>26</b> , Year <b>1998</b>		3. Time of Death <b>3:20 PM</b>	
4a. Facility Name (If not institution, give street and number) <b>11901 JUBAL EARLY COURT</b>				4b. City, Town, or Location of Death <b>POTOMAC</b>		4c. County of Death <b>MONTGOMERY</b>	
5. Social Security Number <b>026-22-3962</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>69</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>05-12-1929</b>	
9. Birthplace (State or Foreign Country) <b>Somerville, Mass</b>							
10a. State <b>MD</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Potomac</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>11901 Jubal Early Ct</b>				10f. Zip Code <b>20854</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yaa or No- If Yaa, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>	
17. Father's Name (First, Middle, Last) <b>Samuel Moore</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Francis Slobodkin</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Martha Feis (Daughter)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9120 Paddock Ln, Potomac, MD 20854</b>			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mt Comfort Crematory</b>		Date <b>12-29-1998</b>		20c. Location - City or Town, State <b>Alexandria, VA</b>	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE - ROCKVILLE, MD. 20852</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Myocardial Infarction</b> a. Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Diabetes Mellitus Type I</b> <b>Hypertensive Cardiovascular Disease</b> <b>Hypo Thyroidism</b>							Approximate Interval Between Onset and Death <b>Unknown</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Diabetes Mellitus Type I</b> <b>Hypertensive Cardiovascular Disease</b> <b>Hypo Thyroidism</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		26. Place of Death (Check only one) Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined	
28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>D 38802</b>		29d. Date signed (Month, Day, Year) <b>12-29-1998</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Osvaldo M. Gonzalez, MD 5530 Wisconsin Ave, Chevy Chase, MD 20815</b>							
31. Date filed (Month, Day, Year) <b>DEC 31 1998</b>				32. Registrar's Signature 			

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Dr. Patricia Tomsko, MD, MEO

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 41304

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last) <b>Annette Heller Goldberg</b>				2. Date of Death Month Day Year <b>Dec. 24 1998</b>				3. Time of Death <b>7:40 PM</b>					
4a. Facility Name (If not institution, give street and number) <b>Hebrew Home of Greater Washington</b>				4b. City, Town, or Location of Death <b>Rockville</b>				4c. County of Death <b>Montgomery</b>					
5. Social Security Number <b>047-10-3912</b>		8. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>83</b> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) <b>Dec. 11 1915</b>		9. Birthplace (State or Foreign Country) <b>Boston, MA</b>	
Usual Residence of Decedent													
10a. State <b>MD</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Rockville</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number <b>6121 Montrose Road</b>				10f. Zip Code <b>20852</b>				10g. Citizen of What Country? <b>USA</b>					
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>4</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>BookKeeper</b>				16b. Kind of Business/Industry <b>Legal Office</b>					
17. Father's Name (First, Middle, Last) <b>Solomon Heller</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Lena Grant</b>							
19a. Informant's Name/Relationship (Type, Print) <b>Michael Goldberg / Son</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7322 Aynsley Ln. McLean, VA 22102</b>							
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metropolitan Crematory</b>				Date <b>12/27/98</b>		20c. Location - City or Town, State <b>Alexandria, VA</b>			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Takoma Funeral Home 254 Carroll St. Washington, DC 20012</b>									
23a. Pertinent diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>ISCHEMIC CARDIOMYOPATHY</b> Due to (or as a consequence of): a. <b>ISCHEMIC CARDIOMYOPATHY</b> b. <b>ISCHEMIC CARDIOMYOPATHY</b> c. <b>ISCHEMIC CARDIOMYOPATHY</b> d. <b>ISCHEMIC CARDIOMYOPATHY</b>													
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown													
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No													
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No													
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No													
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)													
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. Signature and title of certifier 				29c. License number <b>D 180 84</b>				29d. Date signed (Month, Day, Year) <b>DECEMBER 25, 1998</b>					
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>D.D. PATEL, M.D. 6121 MONTROSE RD, ROCKVILLE, MD 20852</b>													
31. Date filed (Month, Day, Year) <b>DEC 31 1998</b>				32. Registrar's Signature 									

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar



98-7494-031

DAVID

GOLDSTEIN ITEMS: #23 PART I, II, 27 PER MEO

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41305

Physician  
/Medical  
Examiner

David S. Goldstein

2. Date of Death  
Month Day Year  
DECEMBER 20, 19983. Time of Death  
10:20A.M.Funeral  
Director

4a. Facility Name (If not institution, give street and number)

304 BELTON ROAD

4b. City, Town, or Location of Death

SILVER SPRING

4c. County of Death

MONTGOMERY

5. Social Security Number

526.17.2562

6. Sex

152 M 20 F

7. Age (In yrs. last birthday)

48

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

12.02.1950

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

MONTGOMERY

10c. City, Town or Location

SILVER SPRING

10d. Inside City Limits

10 Yes 20 No

10e. Street and Number

304 BELTON ROAD

10f. Zip Code

20901

10g. Citizen of What Country?

USA

11. Marital Status

10 Never Married 20 Married  
30 Widowed 40 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
10 Yes 20 No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No -

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
10 Yes 20 No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

INVESTOR I

16b. Kind of Business/Industry

INDEPENDENT

17. Father's Name (First, Middle, Last)

BENJAMIN

GOLDSTEIN

18. Mother's Name (First, Middle, Maiden Surname)

ELIZABETH BELLE

19a. Informant's Name/Relationship (Type, Print)

MARTIN H. WEISS/FRIEND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8211 POSTOAK ROAD, POTOMAC, MARYLAND 20854

20a. Method of Disposition

10 Burial 20 Cremation 30 Removal from State  
40 Donation 50 Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

MT. LEBANON CEMETERY

Date

12/23/98 ADELPHI, MARYLAND

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

EDWARD SAGEL FUNERAL DIRECTION, INC."

1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

FATTY LIVER

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

SCHIZOPHRENIA

23b. Did tobacco use contribute to the cause of death?

10 Yes 20 No 30 Probably 40 Unknown

24a. Was an autopsy  
performed?

10 Yes 20 No

24b. Were autopsy findings  
available prior to  
completion of cause  
of death?

10 Yes 20 No

25. Was case referred to medical  
examiner?  
10 Yes 20 No

Hospital:

10 Inpatient

20 ER/Outpatient

30 DOA

Other:

40 Nursing Home

50 Residence

60 Other (Specify)

27. Manner of Death

10 Natural 50 Pending  
20 Accident investigation  
30 Suicide 60 Could not be  
40 Homicide determined

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?

10 Yes 20 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

DECEMBER 21, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HARRY SMITH A. KOBOR MD

111 Penn Street, Baltimore, Maryland 21201

State  
Registrar

31. Date filed (Month, Day, Year)

DEC 28 1998

32. Registrar's Signature

Benjamin G. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permil. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 41306

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>STANLEY GREENBERG</b>				2. Date of Death Month Day Year <b>12 28 1998</b>		3. Time of Death <b>7:30PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>COLLINGSWOOD NURSING CENTER</b>				4b. City, Town, or Location of Death <b>ROCKVILLE</b>		4c. County of Death <b>MONTGOMERY</b>	
Funeral Director	5. Social Security Number <b>564 52 1353</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>59</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>01 07 1939</b>	9. Birthplace (State or Foreign Country) <b>New York</b>
	Usual Residence of Decedent							
10a. State <b>MD</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Gaithersburg</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>152 Kendrick Place #24</b>				10f. Zip Code <b>20878</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Warehouseman</b>			16b. Kind of Business/Industry <b>Hardware</b>	
17. Father's Name (First, Middle, Last) <b>William Greenberg</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Ruth G. Kendall</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Robert A. Greenberg</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10 Treworthy Rd Gaithersburg, MD 20878</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Judean Memorial Gardens</b>		20c. Location - City or Town, State <b>12-30-98 Olney, MD</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Danzansky-Goldberg Memorial Chapel, Inc.</b> <b>1170 Rockville Pike, Rockville, MD 20852</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immmediate Cause (Final disease or condition resulting in death)  a. <b>Pneumonia</b> Due to (or as a consequence of):  b. <b>Glioblastoma</b> Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death  <b>days</b>  <b>months</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.						23b. Did tobacco use contribute to the cause of death? <b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown		
						24a. Was an autopsy performed? <b>1</b> Yes <b>2</b> No		
						24b. Were autopsy findings available prior to completion of cause of death? <b>1</b> Yes <b>2</b> No		
25. Was case referred to medical examiner? <b>1</b> Yes <b>2</b> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. Date of injury (Month, Day Year)		28b. Time of injury <b>M</b>		28c. Injury at Work? <b>1</b> Yes <b>2</b> No
				28d. Describe how injury occurred		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		
				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <b>Patricia L. Tomsko, MD</b>		29c. License number <b>D51916</b>		29d. Date signed (Month, Day, Year) <b>December 29, 1998</b>
30. Name and address of person who completed cause of death (item 23a) (Type, Print) <b>Patricia L. Tomsko, MD, 11140 Rockville Pike, #348, Rockville, MD 20852</b>								
31. Date filed (Month, Day, Year) <b>DEC 31 1998</b>				32. Registrar's Signature 				

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 41307

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Askale Gebrehana

2. Date of Death

Month Day Year  
December 27, 1998

3. Time of Death

5:55 AM

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

021-74-1564

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

87

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
July 11, 1911

9. Birthplace (State or Foreign Country)

Ethiopia

Usual Residence of Decedent

10a. State

Mass.

10b. County

Suffolk

10c. City, Town or Location

Brookline

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

1469 Beacon Street

10f. Zip Code

02446

10g. Citizen of What Country?

Ethiopia

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
6

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Farmer

16b. Kind of Business/Industry

Agriculture

17. Father's Name (First, Middle, Last)

Gebrehana Wondemanhe

18. Mother's Name (First, Middle, Maiden Surname)

Emama

19a. Informant's Name/Relationship (Type, Print)

Dagne Gizaw, son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8008 Eastern Drive, #101, Silver Spring, Maryland

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Gate of Heaven Cemetery 12/30/98 Silver Spring, Md.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

McGuire Funeral Service, Inc.  
7400 Georgia Ave. N.W., Washington, D.C.23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)a. SMALL BOWEL INFARCTION  
Due to (or as a consequence of):

2 WEEKS

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. MESENTERIC ARTERY ISCHEMIA  
Due to (or as a consequence of):

&gt; 2 WEEKS

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PNEUMONIA; HYPONATREMIA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Martin C. Sharkey, MD

29c. License number

D08944

29d. Date signed (Month, Day, Year)

12/27/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARTIN C. SHARKEY, MD

3720 PARKWAY AVE.  
KENSINGTON, MD 20895

31. Date filed (Month, Day, Year)

DEC 31 1998

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Page 10  
Date 10/10/10

Received from Mr. [Name] the sum of \$100.00 for [Purpose]

Witness my hand and seal this 10th day of October 2010.

Signature of [Name]  
[Title]  
[Organization]

Signature of [Name]  
[Title]  
[Organization]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41308

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Muriel A. Geolot</b>				2. Date of Death Month Day Year <b>Dec. 22, 1998</b>		3. Time of Death <b>6:30PM</b>																		
	4a. Facility Name (If not institution, give street and number) <b>Woodside Nursing Home</b>				4b. City, Town, or Location of Death <b>Silver Spring</b>		4c. County of Death <b>Montgomery</b>																		
Funeral Director	5. Social Security Number <b>579-66-8817</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>85</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>June 21 1913</b>																		
	9. Birthplace (State or Foreign Country) <b>Canada</b>																								
Usual Residence of Decedent																									
10a. State <b>MD</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Silver Spring</b>			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No																		
10e. Street and Number <b>9101 Second Avenue</b>				10f. Zip Code <b>20906</b>		10g. Citizen of What Country? <b>USA</b>																			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>																			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>																			
17. Father's Name (First, Middle, Last) <b>Frederick C. Bishop</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Minnie Boulton</b>																					
19a. Informant's Name/Relationship (Type, Print) <b>Alan C. Bishop - Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1722 Eye St. N.W. Washington, D. C. 20006</b>																					
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Balt. - Wash. Crematory</b>		Date <b>12/28/98</b>		20c. Location - City or Town, State <b>Laurel, MD</b>																	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Joseph Gawler's Sons INC, 5130 Wisconsin Ave. NW Washington, DC 20016</b>																					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																									
<table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a.</td> <td><b>Respiratory Insufficiency</b></td> <td>Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>b.</td> <td><b>Chronic Obstructive Lung Disease</b></td> <td>Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>c.</td> <td></td> <td>Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d.</td> <td></td> <td>Due to (or as a consequence of):</td> <td></td> </tr> </table>									Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	<b>Respiratory Insufficiency</b>	Due to (or as a consequence of):		b.	<b>Chronic Obstructive Lung Disease</b>	Due to (or as a consequence of):		c.		Due to (or as a consequence of):		d.		Due to (or as a consequence of):	
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	<b>Respiratory Insufficiency</b>	Due to (or as a consequence of):																						
	b.	<b>Chronic Obstructive Lung Disease</b>	Due to (or as a consequence of):																						
	c.		Due to (or as a consequence of):																						
	d.		Due to (or as a consequence of):																						
23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown																									
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred																	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)																					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																									
29b. Signature and title of certifier 				29c. License number <b>D 24886</b>		29d. Date signed (Month, Day, Year) <b>Dec. 23, 1998</b>																			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Mark H. Eig MD., 10801 Lockwood Dr. #280 Silver Spring, MD 20901-1563</b>																									
31. Date filed (Month, Day, Year) <b>DEC 30 1998</b>				32. Registrar's Signature 																					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "Natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1940-1941

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2017-2018

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State of Maryland / Department of Health and Mental Hygiene

98 41309

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Carma Mayjel Gibbs

2. Date of Death

Month Day Year  
December 27, 1998

3. Time of Death

11:32 PM

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

274-10-6144

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
July 19, 1910

9. Birthplace (State or Foreign Country)

Ohio

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7402 MacKenzie Court

10f. Zip Code

20817

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Doctor's Office

17. Father's Name (First, Middle, Last)

Perry Porter Dugan

18. Mother's Name (First, Middle, Maiden Surname)

Mayjel Almyra Woodruff

19a. Informant's Name/Relationship (Type, Print)

Jerilyn K. Gibbs (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7402 MacKenzie Court, Bethesda, Maryland 20817

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Chesapeake Crematory

Date

12-29-98

20c. Location - City or Town, State

Beltsville, Maryland

21. Signature of Funeral Service Licensee

Carol A. Delmon

22. Name and Address of Facility

Rapp Funeral Services, P.A.  
933 Gist Avenue, Silver Spring, Maryland 2091023a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Mesenteric Artery Insufficiency

Approximate  
Interval Between  
Onset and Death

1 week

Due to (or as a consequence of):

b. ASVD

10 years

Due to (or as a consequence of):

c. Hyperlipidemia

20 years

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Gastrointestinal Hemorrhage

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

T.J. McNamara

29c. License number

D32610

29d. Date signed (Month, Day, Year)

December 28, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

T.J. McNamara, M.D., 5602 Shields Drive, Bethesda, Maryland 20817

31. Date filed (Month, Day, Year)

DEC 30 1998

32. Registrar's Signature

Beverly B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41310

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) HERMAN E. HENN				2. Date of Death Month Day Year DECEMBER 21, 1998				3. Time of Death 10:15 P.M.	
	4a. Facility Name (If not institution, give street and number) 2307 PARKER AVENUE				4b. City, Town, or Location of Death SILVER SPRING				4c. County of Death MONTGOMERY	
Funeral Director	5. Social Security Number 578-03-8122		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 90 Yrs.		8. Date of Birth (Month, Day, Year) NOV. 05, 1908		9. Birthplace (State or Foreign Country) GERMANY	
	Usual Residence of Decedent				10a. State MARYLAND		10b. County MONTGOMERY		10c. City, Town or Location SILVER SPRING	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number 2307 PARKER AVENUE				10f. Zip Code 20902	
	10g. Citizen of What Country? UNITED STATES OF AMERICA				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: WHITE				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) AUTO BODY REPAIR				16b. Kind of Business/Industry AUTOMOTIVE				17. Father's Name (First, Middle, Last) KARL MARTIN HENN	
	18. Mother's Name (First, Middle, Maiden Surname) LUISE EGOLF				19a. Informant's Name/Relationship (Type, Print) ELLEN H. MURRAY (NIECE)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 310 KNOLL CREEK CIRCLE CHATTANOOGA TENNESSEE 37415	
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) GATE OF HEAVEN CEMETERY				20c. Location - City or Town, State SILVER SPRING MARYLAND	
	21. Signature of Funeral Service Licensee <i>Sam S. Schwartz</i>				22. Name and Address of Facility HINES-RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVENUE SILVER SPRING MARYLAND 20904-2891				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. UREMIA Due to (or as a consequence of): b. METASTATIC CARCINOMA OF PROSTATE Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	
	23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined	
	28a. Date of Injury (Month, Day Year)				28b. Time of Injury M				28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		
29b. Signature and title of certifier <i>John B. Umhau M.D.</i>				29c. License number D11024				29d. Date signed (Month, Day, Year) DECEMBER 23, 1998		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOHN B. UMHAU, M.D., 8805 CONNECTICUT AVENUE CHEVY CHASE MARYLAND 20815				31. Date filed (Month, Day, Year) DEC 29 1998				32. Registrar's Signature <i>Benjamin B. Sparks</i>		

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41311

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>FLOYD H. HALL</b>				2. Date of Death Month Day Year <b>DEC. 24, 1998</b>		3. Time of Death <b>4:00 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>9311 All Saints Road</b>				4b. City, Town, or Location of Death <b>Laurel</b>		4c. County of Death <b>HOWARD</b>	
Funeral Director	5. Social Security Number <b>213-20-0028</b>		6. Sex <b>1 M 2 F</b>		7. Age (In yrs. last birthday) <b>76</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Aug. 23, 1922</b>	
	9. Birthplace (State or Foreign Country) <b>Virginia</b>		10a. State <b>MD</b>		10b. County <b>Howard</b>		10c. City, Town or Location <b>Laurel</b>	
Usual Residence of Decedent		10d. Inside City Limits <b>1 Yes 2 No</b>		10e. Street and Number <b>9311 All Saints Road</b>		10f. Zip Code <b>20723</b>		
10g. Citizen of What Country? <b>U.S.A.</b>		11. Marital Status <b>1 Never Married 2 Married</b> <b>3 Widowed 4 Divorced</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>1 Yes 2 No</b> If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 Yes 2 No</b> Specify:		
14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		15. Decedent's Education (Specify only highest grade completed) <b>5th</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Plant Equipment Operator</b>		16b. Kind of Business/Industry <b>Montg. Co. Board of Ed.</b>		
17. Father's Name (First, Middle, Last) <b>Samuel Hall</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Alice Lewis</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Allen S. Hall (Son)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9311 All Saints Rd., Laurel, MD 20723</b>				
20a. Method of Disposition <b>1 Burial 2 Cremation 3 Removal from State</b> <b>4 Donation 5 Other (Specify)</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Meadowridge Mem. Park</b>		20c. Location - City or Town, State <b>Elkridge, MD</b>		20d. Date <b>12/30/98</b>		
21. Signature of Funeral Service Licensee <i>George R. Snowden</i>		22. Name and Address of Facility <b>SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Dilated Cardiomyopathy</b> Due to (or as a consequence of): <b>b. Hypertension</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
Approximate Interval Between Onset and Death <b>3 years</b> <b>10 yrs</b>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Myocardial infarction</b>						23b. Did tobacco use contribute to the cause of death? <b>1 Yes 2 No 3 Probably 4 Unknown</b>		
24a. Was an autopsy performed? <b>1 Yes 2 No</b>						24b. Were autopsy findings available prior to completion of cause of death? <b>1 Yes 2 No</b>		
25. Was case referred to medical examiner? <b>1 Yes 2 No</b>		26. Place of Death (Check only one) Hospital: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> Other: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b>						
27. Manner of Death <b>1 Natural 2 Accident 3 Suicide 4 Homicide</b> <b>5 Pending Investigation 6 Could not be determined</b>		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <b>1 Yes 2 No</b>		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <b>1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> <b>2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>								
29b. Signature and title of certifier <i>Eric Simbell M.D.</i>		29c. License number <b>D36820</b>		29d. Date signed (Month, Day, Year) <b>12/28/98</b>				
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>ERIC SIMBELL M.D. 3905 National Drive Suite 370 Burtonsville MD 20866</b>								
31. Date filed (Month, Day, Year) <b>DEC 30 1998</b>		32. Registrar's Signature <i>Bernice G. Sparks</i>						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Elizabeth Marie Hamill

2. Date of Death

Month

Day

Year

Dec

28

98

3. Time of Death

12:25 pm

4a. Facility Name (If not institution, give street and number)

Charlestown Care Center

4b. City, Town, or Location of Death

Catonsville

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

403-10-3855

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 7, 1910

9. Birthplace (State or Foreign Country)

Kentucky

Usual Residence of Decedent

10e. State

MD

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

28813 Greenberry Drive

10f. Zip Code

20882

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

John Musterman

18. Mother's Name (First, Middle, Maiden Surname)

Adeline Wagner

19a. Informant's Name/Relationship (Type, Print)

Jeanne M. Atzert (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

28813 Greenberry Drive, Gaithersburg, MD 20882

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

12/31/98

20c. Location - City or Town, State

Silver Spring, MD

21. Signature of Funeral Service Licensee

Tracy A. Shiver

22. Name and Address of Facility

Francis J. Collins Funeral  
Home, Inc. 500 University Blvd. West  
Silver Spring, MD 2090123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. End stage Congestive Heart failure

Years

Due to (or as a consequence of)

b. Aortic Stenosis

Years

Due to (or as a consequence of)

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24e. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Andres Salazar MD

29c. License number

D 51051

29d. Date signed (Month, Day, Year)

December 28, 1998

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Andres Salazar, 711 Maiden choice Lane, Catonsville, MD, 21228

31. Date filed (Month, Day, Year)

DEC 29 1998

32. Registrar's Signature

Dennis B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Name: Elizabeth Hamill  
Division of Vital Records, P.O. Box 68760,

10





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Wesley G. Harding

2. Date of Death

Dec 22, 1998

3. Time of Death

09:13am

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

577-16-6331

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

78

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

October 31, 1920

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

623 Smallwood Road

10f. Zip Code

20850

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: World War II

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Judge

16b. Kind of Business/Industry

Veterans Administration

17. Father's Name (First, Middle, Last)

Joseph H. Harding

18. Mother's Name (First, Middle, Maiden Surname)

Eva E. Wright

19a. Informant's Name/Relationship (Type, Print)

Rita E. Harding/ Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

623 Smallwood Road, Rockville, Maryland 20850

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MD Veterans Cemetery, Cheltenham

20c. Location - City or Town, State

Cheltenham, Maryland

21. Signature of Funeral Service Licensee

MQ0689

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/  
Rockville, Inc. 300 West Montgomery Avenue,  
Rockville, Maryland 20850-2805

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Asystole

Approximate Interval Between Onset and Death

20 min

Due to (or as a consequence of):

Coronary Artery Disease

Due to (or as a consequence of):

Anoxic Encephalopathy

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

26a. Date of Injury (Month, Day Year)

26b. Time of Injury

26c. Injury at Work?

1 ☐ Yes 2 ☐ No

26d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

Dec 22, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kewal Sharma Md

10620 Georgia Ave Silver Spring Md 20902

31. Date filed (Month, Day, Year)

DEC 28 1998

32. Registrar's Signature

Beverly B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 26a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Jose Balsera Hernandez

2. Date of Death

Month Day Year  
December 27, 1998

3. Time of Death

20:22pm

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Shady Grove Adventist Hospital

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

5. Social Security Number

N/A

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Dec. 8, 1919

9. Birthplace (State or Foreign Country)

Spain

Usual Residence of Decedent

10a. State

Md.

10b. County

Montgomery

10c. City, Town or Location

Montgomery Village

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

18319 Lost Knife Circle #104

10f. Zip Code

20886

10g. Citizen of What Country?

Spain

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
8

College (1-4 or 5+)

18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Car Dealer

16b. Kind of Business/Industry

Automotive

17. Father's Name (First, Middle, Last)

Angel Balsera

18. Mother's Name (First, Middle, Maiden Surname)

Josefa Hernandez

19a. Informant's Name/Relationship (Type, Print)

Pilar Diaz Bese (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

18319 Lost Knife Circle #104 Montgomery Village, Md. 20886

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory

Date

Dec. 30, 1998

20c. Location - City or Town, State

Alexandria, Va.

21. Signature of Funeral Service Licensee

Curtis E. Day

22. Name and Address of Facility

DeVol Funeral Home  
10 East Deer Park Dr. Gaithersburg, Md. 20877

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Arrhythmia  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

minutes

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Brett Gamma M.D.

29c. License number

051980

29d. Date signed (Month, Day, Year)

December 27, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Brett Gamma M.D. 9901 Medical Center Dr. Rockville, Md. 20850

31. Date filed (Month, Day, Year)

DEC 31 1998

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 41315

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last) Walter Harrison Hadaway III 2. Date of Death Month 12 Day 29 Year 98 3. Time of Death 830 pm

Funeral  
Director

4a. Facility Name (If not institution, give street and number) Chestertown Nursing & Rehab. 4b. City, Town, or Location of Death Chestertown 4c. County of Death Kent

5. Social Security Number 218-16-6929 6. Sex ☒ M ☐ F 7. Age (In yrs. last birthday) 74 Yrs. 8. Date of Birth (Month, Day, Year) July 8, 1924 9. Birthplace (State or Foreign Country) Maryland

Usual Residence of Decedent 10a. State Maryland 10b. County Kent 10c. City, Town or Location Chestertown 10d. Inside City Limits ☐ Yes ☒ No

10e. Street and Number 150 Flatland Road Apt. 56 10f. Zip Code 21620 10g. Citizen of What Country? USA

11. Marital Status ☐ Never Married ☐ Married ☒ Widowed ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? ☐ Yes ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ Yes ☒ No Specify: 14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) Dairy Farmer 16a. Decedent's Usual Occupation (Give kind of work done during most of working life DO NOT use retired) Dairy Farmer 16b. Kind of Business/Industry Agriculture

17. Father's Name (First, Middle, Last) Walter Harrison Hadaway, Jr. 18. Mother's Name (First, Middle, Maiden Surname) Nannie Newcomb

19a. Informant's Name/Relationship (Type, Print) Helen Bryden/Neice 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 104 Primrose Road, Chestertown, MD 21620

20a. Method of Disposition ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Wesley Chapel Cemetery Date 1/4/99 20c. Location - City or Town, State Rock Hall, MD

21. Signature of Funeral Service Licensee Kirk J. Helfenbein 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, MD 21620

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Renal Failure Due to (or as a consequence of): ~ 1 week Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last { Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hemodialysis @ 3yrs pt. Stopped dialysis ~ 1wk ago. 23b. Did tobacco use contribute to the cause of death? ☐ Yes ☐ No ☐ Probably ☒ Unknown

ASCVDs; S/P CABG; MTN: DM Type II; Nephrolithiasis; Barrett's Esophagus; Renal Art. Stenosis. 24a. Was an autopsy performed? ☐ Yes ☒ No 24b. Were autopsy findings available prior to completion of cause of death? ☐ Yes ☐ No

25. Was case referred to medical examiner? ☐ Yes ☒ No 26. Place of Death (Check only one) Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death ☒ Natural ☐ Accident ☐ Suicidal ☐ Homicide ☐ Pending Investigation ☐ Could not be determined 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? ☐ Yes ☒ No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier Neil Stoddard 29c. License number D 50996 29d. Date signed (Month, Day, Year) 12/29/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Neil Stoddard 100 Brown Street, Chestertown, MD 21620

31. Date filed (Month, Day, Year) DEC 31 1998 32. Registrar's Signature B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Prof. C. Smith 1891

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41316

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

LEON DEAN HUFF

2. Date of Death

Dec 23 1998 5:15PM

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

The Memorial Hospital

4b. City, Town, or Location of Death

Easton

4c. County of Death

Talbot

5. Social Security Number

220-28-4838

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

66

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

NOV. 16, 1932

9. Birthplace (State or Foreign Country)

PENNA.

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

TALBOT

10c. City, Town or Location

EASTON

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

117 CHOPTANK AVENUE

10f. Zip Code

21601

10g. Citizen of What Country?

U.S.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1951-54

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

REPAIRMAN

16b. Kind of Business/Industry

TELEPHONE

17. Father's Name (First, Middle, Last)

IVAN HUFF

18. Mother's Name (First, Middle, Maiden Surname)

GERTRUDE GEISE

19a. Informant's Name/Relationship (Type, Print)

MOIRA F. HUFF /WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

117 CHOPTANK AVE. EASTON, MARYLAND 21601

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

CHESAPEAKE CREM. CTR.

Date

12-24-98

20c. Location - City or Town, State

CHESTER, MD.

21. Signature of Funeral Service Licensee

M. F. Newnam CFSP

22. Name and Address of Facility

FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME  
200 S. HARRISON ST., EASTON, MD. 21601

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Non-small cell lung carcinoma, widely metastatic

&gt; 8 months

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

None

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Robert W. Trever, M.D.

29c. License number

D10938

29d. Date signed (Month, Day, Year)

12-24-98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROBERT W. TREVER, M.D. 7696 OCEAN GATEWAY EASTON, MARYLAND 21601

31. Date filed (Month, Day, Year)

DEC 28 1998

32. Registrar's Signature

B. Sparks

State  
Registrar

Leon Huff

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41317

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>SAMUEL INTRATER</b>					2. Date of Death Month Day Year <b>DECEMBER 30 1998</b>		3. Time of Death <b>2:00AM</b>
	4a. Facility Name (If not institution, give street and number) <b>SUBURBAN HOSPITAL</b>					4b. City, Town, or Location of Death <b>BETHESDA</b>		4c. County of Death <b>MONTGOMERY</b>
Funeral Director	5. Social Security Number <b>033 22 1432</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>73</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>MARCH 23 1925</b>		9. Birthplace (State or Foreign Country) <b>ILLINOIS</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>MARYLAND</b>	10b. County <b>MONTGOMERY</b>	10c. City, Town or Location <b>BETHESDA</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number <b>6701 MELODY LANE</b>			10f. Zip Code <b>20817</b>		10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>5+</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>ATTORNEY</b>			16b. Kind of Business/Industry <b>SELF EMPLOYED</b>		
	17. Father's Name (First, Middle, Last) <b>CHARLES INTRATER</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>CELIA HOLLANDER</b>		
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>NATALIE INTRATER/WIFE</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6701 MELODY LANE BETHESDA, MARYLAND 20817</b>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>JUDEAN MEMORIAL GARDENS</b>		Date <b>1/3/99</b>	20c. Location - City or Town, State <b>OLNEY MARYLAND</b>	
	21. Signature of Funeral Service Licensee <i>[Signature]</i>			22. Name and Address of Facility <b>DANZANSKY GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE ROCKVILLE, MARYLAND 20852</b>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. <b>Cerebral hemorrhage</b> Due to (or as a consequence of):							Approximate Interval Between Onset and Death <b>3 days</b>
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.							
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <b>Dr Paul Ketting MD</b>				29c. License number <b>D21435</b>		29d. Date signed (Month, Day, Year) <b>December 30, 1998</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr Paul Ketting MD 2101 Medical Park Drive Silver Spring MD 20902</b>								
31. Date filed (Month, Day, Year) <b>DEC 31 1998</b>		32. Registrar's Signature <i>[Signature]</i>						

12-30-98 145am  
Baltimore, Maryland 21215-0020

Samuel Intrater  
Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Wm. H. Hunt

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41318

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Clara Jackson

2. Date of Death

Dec 26, 1998

3. Time of Death

09:50pm

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

577-26-2196

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

102 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

6. Date of Birth

Nov. 21, 1896

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5721 Grosvenor Lane

10f. Zip Code

20814

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
8

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Elevator Operator / Cook

16b. Kind of Business/Industry

Department Stores / Blair House

17. Father's Name (First, Middle, Last)

(Unavailable) Reddix

18. Mother's Name (First, Middle, Maiden Surname)

Unavailable

19a. Informant's Name/Relationship (Type, Print)

Cheryl Fish-Parcham (friend)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1347 Newton Street, NE, Washington, DC 20017

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Glenwood Cemetery

Date

12-29-98

20c. Location - City or Town, State

Washington, DC

21. Signature of Funeral Service Licensee

► *Eileen H. Rapp*

22. Name and Address of Facility

Rapp Funeral Services, P. A.

933 Gist Avenue, Silver Spring, MD 20910

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Dehydration

a. Due to (or as a consequence of):

b. Altered mental status

c. Due to (or as a consequence of):

acute urinary tract infection

d. Due to (or as a consequence of):

Diabetes mellitus

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Senile Dementia

ASCVD

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ NoHospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

► *George Patrick III*

29c. License number

D 17724

29d. Date signed (Month, Day, Year)

Dec 28, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

George Patrick III MD 9221 Colesville Rd Silver Spring Md 20910

State  
Registrar

31. Date filed (Month, Day, Year)

DEC 29 1998

32. Registrar's Signature

*Benita B. Sparks*

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

2



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last) <b>Leo M. Jacobs</b>				2. Date of Death Month <b>Dec</b> Day <b>24</b> Year <b>1998</b>		3. Time of Death <b>10:50 PM</b>	
4a. Facility Name (If not institution, give street and number) <b>Holy Cross Hospital</b>				4b. City, Town, or Location of Death <b>Silver Spring</b>		4c. County of Death <b>Montgomery</b>	
5. Social Security Number <b>570-07-6086</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (in yrs. last birthday) <b>80</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>July 13, 1918</b>	
10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Silver Spring</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>1400 East West Highway, #423</b>				10f. Zip Code <b>20910</b>		10g. Citizen of What Country? <b>United States</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5+</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Teacher</b>		16b. Kind of Business/Industry <b>Deaf Education</b>			
17. Father's Name (First, Middle, Last) <b>Monroe Jacobs</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Elizabeth Keesing</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Sheila Jacobs (daughter)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4101 Howe Street, #106, Oakland, CA 94611</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Sunset View Cemetery</b>		Date <b>1-4-99</b>		20c. Location - City or Town, State <b>El Cerrito, California</b>	
21. Signature of Funeral Service Licensee <b>Allen H. Rapp</b>				22. Name and Address of Facility <b>Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Pneumonia</b> Due to (or as a consequence of):  <b>b.</b> Due to (or as a consequence of):  <b>c.</b> Due to (or as a consequence of):  <b>d.</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Diabetes mellitus</b> <b>Renal insufficiency</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
28e. Location (Street and Number or Rural Route Number, City or Town, State)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Rajinder K. Sarin</b>		29c. License number <b>D13548</b>		29d. Date signed (Month, Day, Year) <b>12-25-98</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>RAJINDER K. SARIN MD 10801 Lockwood Drive Suite 208 Silver Spring MD 20901</b>							
31. Date filed (Month, Day, Year) <b>DEC 28 1998</b>		32. Registrar's Signature <b>B. Sparks</b>					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41320

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Hrant

Jamgochian

2. Date of Death

Month Day Year  
December 27, 1998

3. Time of Death

12:15 AM

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

577-82-3564

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

91 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Jan. 1, 1907

9. Birthplace (State or Foreign Country)

Turkey

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3764 Bel Pre Road, #8

10f. Zip Code

20906

10g. Citizen of What Country?

Lebanon

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (14 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Watchmaker

16b. Kind of Business/Industry

Self-employed

17. Father's Name (First, Middle, Last)

Hovnan Jamgochian

18. Mother's Name (First, Middle, Maiden Surname)

Eghisapeth (Unavailable)

19a. Informant's Name/Relationship (Type, Print)

Zevart H. Jamgochian (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Same as 10

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

12-29-98

20c. Location - City or Town, State

Silver Spring, Maryland

21. Signature of Funeral Service Licensee

▶ Ellen H. Rapp

22. Name and Address of Facility

Rapp Funeral Services, P. A.

933 Gist Avenue, Silver Spring, MD 20910

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

shock, or heart failure. List only one cause on each line.

Approximate

Interval Between

Onset and Death

Immediate Cause (Final  
disease or condition  
resulting in death)

a. SEPTICEMIA

Due to (or as a consequence of):

1 WEEK

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS; OSTEOMYELITIS OF JAW;

RECURRENT PNEUMONIA; HYPERTENSIVE CARDIOVASCULAR

DISEASE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy

performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings

available prior to

completion of cause

of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical

examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

Investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

M

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)

29a. Certifier

(Check only

one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

▶ Martin C. Shargel MD

29c. License number

D08944

29d. Date signed (Month, Day, Year)

12/27/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARTIN C. SHARGEL, M.D.

3720 FARRAGUT AVE.

KEDGINGTON, MD - 20895

31. Date filed (Month, Day, Year)

DEC 28 1998

32. Registrar's Signature

▶ Beverly B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



THE UNIVERSITY OF CHICAGO  
DIVISION OF THE PHYSICAL SCIENCES  
DEPARTMENT OF CHEMISTRY

1961

Dr. J. H. Duerksen  
Department of Chemistry  
University of Chicago

Dr. J. H. Duerksen  
Department of Chemistry  
University of Chicago

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Form #3, #9, 12/30/98, BW, Montgomery, State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Ford Anthony Kalil, Jr.</b>				2. Date of Death Month <b>December</b> Day <b>22</b> Year <b>1998</b>		3. Time of Death <b>4:10 P.M.</b>		
	4a. Facility Name (If not institution, give street and number) <b>6923 Barrett Lane</b>				4b. City, Town, or Location of Death <b>Bethesda</b>		4c. County of Death <b>Montgomery</b>		
Funeral Director	5. Social Security Number <b>262-50-8231</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>63</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Aug. 14, 1935</b>	9. Birthplace (State or Foreign) <b>Florida</b>	
	Usual Residence of Decedent								
10a. State <b>MD</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Bethesda</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>6923 Barrett Lane</b>				10f. Zip Code <b>20814</b>		10g. Citizen of What Country? <b>USA</b>			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>3</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Antique Dealer</b>			16b. Kind of Business/Industry <b>Antiques</b>		
17. Father's Name (First, Middle, Last) <b>Ford A. Kalil</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Margaret Redmond</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Renee R. Kalil - Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6923 Barrett Lane Bethesda, MD 20814</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gate of Heaven Cemetery</b>		Date <b>12/26/98</b>		20c. Location - City or Town, State <b>Silver Spring, MD</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Joseph Gawler's Sons 5130 WI Ave. N.W. Washington, D. C. 20016</b>					
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Cancer of Lung</b>  Due to (or as a consequence of):  Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):								Approximate Interval Between Onset and Death <b>1 Year</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Arteriosclerotic Heart Disease</b>						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
			28d. Describe how injury occurred			28e. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier 			29c. License number <b>D 15049</b>		29d. Date signed (Month, Day, Year) <b>December 23, 1998</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>John F. Gustafson, M. D. 5480 Wisconsin Ave. #1625 Chevy Chase, MD 20815</b>									
31. Date filed (Month, Day, Year) <b>DEC 28 1998</b>			32. Registrar's Signature 						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 41322

Amend #1, 1/6/99, BMW, Montg. Co. per physician Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

YOU CHUL KIM

2. Date of Death  
Month Day Year

December 28 1998

3. Time of Death

12:05 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

WASHINGTON ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

5. Social Security Number

NONE

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

40 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

MARCH 4, 1958

9. Birthplace (State or Foreign Country)

KOREA

Usual Residence of Decedent

10a. State

MD

10b. County

MONTGOMERY

10c. City, Town or Location

POTOMAC

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

7612 CODDLE HARBOR LANE

10f. Zip Code

20854

10g. Citizen of What Country?

KOREA

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: KOREAN

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

MEDICAL DOCTOR

16b. Kind of Business/Industry

MEDICINE

17. Father's Name (First, Middle, Last)

TAEK IL KIM

18. Mother's Name (First, Middle, Maiden Surname)

OKBIN IM

19a. Informant's Name/Relationship (Type, Print)

WON CHUL KIM / BROTHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10709 PEBBLE BROOK LANE POTOMAC MD 20854

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

NORBECK MEMORIAL PARK

Date

12/30/98

20c. Location - City or Town, State

OLNEY MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

HINES-RINALDI FUNERAL HOME, INC.

11800 NEW HAMPSHIRE AVE. SILVER SPRING MD 20904

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Gastric Carcinoma

2 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

26. Place of Death (Check only one)

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, tectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D38451

29d. Date signed (Month, Day, Year)

12/28/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jeffrey Bernstein MD 7610 Carroll Ave, #250, Takoma Park MD 20912

State  
Registrar

31. Date filed (Month, Day, Year)

DEC 29 1998

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-697-1000.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 41323

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>M. David Kreider</b>					2. Date of Death Month Day Year <b>December 23, 1998</b>			3. Time of Death <b>2:07 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Montgomery General Hospital</b>					4b. City, Town, or Location of Death <b>Olney</b>			4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>213-12-1977</b>	6. Sex <b>1 M 2 F</b>	7. Age (In yrs. last birthday) <b>84</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>June 5, 1914</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <b>MD</b>	10b. County <b>Montgomery</b>	10c. City, Town or Location <b>Silver Spring</b>			10d. Inside City Limits <b>1 Yes 2 No</b>				
	10e. Street and Number <b>14400 Homecrest Road</b>			10f. Zip Code <b>20906</b>		10g. Citizen of What Country? <b>USA</b>				
	11. Marital Status <b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>1 Yes 2 No</b> If Yes, Give Year or Dates: <b>1942-43</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 Yes 2 No Specify:</b>		14. Race - American Indian, Black, White, etc. <b>Specify: White</b>			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>5+</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Patent Attorney</b>			16b. Kind of Business/Industry <b>Law</b>			
	17. Father's Name (First, Middle, Last) <b>Milton H. Kreider</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Maude Riggles</b>				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Mildred B. Kreider (wife)</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>14400 Homecrest Road, Silver Spring, MD 20906</b>				
	20a. Method of Disposition <b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metropolitan Crematory</b>			Date <b>12/28/98</b>		20c. Location - City or Town, State <b>Alexandria, Virginia</b>		
	21. Signature of Funeral Service Licensee <i>Kevin Gutowski</i>					22. Name and Address of Facility <b>Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901</b>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Intracerebral Bleed</b> Due to (or as a consequence of): <b>Stroke</b> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Hypertension</b> <b>Arrhythmia Fibrillation</b>					Approximate Interval Between Onset and Death <b>6 hours</b> <b>6 hours</b>				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hypertension</b> <b>Arrhythmia Fibrillation</b>					23b. Did tobacco use contribute to the cause of death? <b>1 Yes 2 No 3 Probably 4 Unknown</b>				
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <b>1 Yes 2 No</b>					24b. Were autopsy findings available prior to completion of cause of death? <b>1 Yes 2 No</b>				
	25. Was case referred to medical examiner? <b>1 Yes 2 No</b>					26. Place of Death (Check only one) Hospital: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> Other: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b>				
	27. Manner of Death <b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined</b>		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <b>1 Yes 2 No</b>		28d. Describe how Injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) <b>1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>					29b. Signature and title of certifier <i>W. A. Ferris MD</i>				
State Registrar	29c. License number <b>D31918</b>					29d. Date signed (Month, Day, Year) <b>December 23, 1998</b>				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>WARREN A. FERRIS, 3305 NORTHLEASURE WALK, SILVER SPRING, MARYLAND 20906</b>									
State Registrar	31. Date filed (Month, Day, Year) <b>DEC 28 1998</b>					32. Registrar's Signature <i>B. Sparks</i>				





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Mary Krucelyak</b>				2. Date of Death Month <b>December</b> Day <b>28</b> Year <b>1998</b>		3. Time of Death <b>8:30A.</b>		
	4a. Facility Name (If not institution, give street and number) <b>5715 Vassar Drive</b>				4b. City, Town, or Location of Death <b>College Park</b>		4c. County of Death <b>Prince George's</b>		
Funeral Director	5. Social Security Number <b>578-76-1228</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>93</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Aug. 19, 1905</b>	9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>	
	Usual Residence of Decedent								
10a. State <b>Maryland</b>		10b. County <b>Prince George's</b>		10c. City, Town or Location <b>College Park</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10a. Street and Number <b>5715 Vassar Drive</b>				10f. Zip Code <b>20740</b>		10g. Citizen of What Country? <b>United States</b>			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>			16b. Kind of Business/Industry <b>own home</b>		
17. Father's Name (First, Middle, Last) <b>Andrew Pongrance</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Elizabeth Hornak</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Irene Ferber (Daughter)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5906 Bryn Mawr Rd. College Park, Maryland 20740</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Resurrection Cemetery 12/31/1998</b>		Data		20c. Location - City or Town, State <b>Clinton, Maryland</b>			
21. Signature of Funeral Service Licensee <b>Donald V. Borgwardt</b>				22. Name and Address of Facility <b>Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705</b>					
23a. Part I. Enter the disease, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>Dehydration</b> Due to (or as a consequence of):  b. <b>Dementia, Alzheimer's type.</b> Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death  <b>3 days</b>  <b>5 years</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
						24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier <b>Michael Berard, MD</b>		29c. License number <b>026287</b>		29d. Date signed (Month, Day, Year) <b>December 28, 1998</b>					
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Michael Berard, M.D. 7305 Baltimore Ave., #107 College Park, Maryland 20740</b>									
31. Date filed (Month, Day, Year) <b>DEC 29 1998</b>		32. Registrar's Signature <b>Benita B. Sparks</b>							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10

2

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41325

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Josephine Powell Kain				2. Date of Death Month Day Year December 29 1998		3. Time of Death 1747		
	4a. Facility Name (If not institution, give street and number) Kent & Queen Anne's Hospital				4b. City, Town, or Location of Death Chestertown		4c. County of Death Kent		
Funeral Director	5. Social Security Number 218-20-6403		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 87 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) November 12, 1911		
	9. Birthplace (State or Foreign Country) Maryland								
To Be Completed by Funeral Director	Usual Residence of Decedent		10a. State Maryland		10b. County Kent		10c. City, Town or Location Chestertown		
	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No								
	10e. Street and Number 200 Morgnac Road		10f. Zip Code 21620		10g. Citizen of What Country? USA				
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerk		16b. Kind of Business/Industry United States Postal Service				
	17. Father's Name (First, Middle, Last) Alex Powell				18. Mother's Name (First, Middle, Maiden Surname) Sara Newnam				
	19a. Informant's Name/Relationship (Type, Print) Adelaide Ernest/Sister				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 700 Crystal Beach Road, Cecilton, MD 21913				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Galena Cemetery		Date 1/3/99		20c. Location - City or Town, State Galena, MD		
	21. Signature of Funeral Service Licensee <i>Kirk J. Helfenbein</i>				22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620				
	23a. Part I. Enter the disease or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. <i>Small Bowel Obstruction</i> Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown									
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No									
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No									
Physician /Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>① Bilateral lower lobe pneumonia</i> <i>② Acute Atrial Fibrillation &amp; Flutter</i> <i>③ CRF ④ Severe Dementia</i>								
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury et Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
State Registrar	29b. Signature and title of certifier <i>K. K. Wun, MD</i>		29c. License number <i>D21313</i>		29d. Date signed (Month, Day, Year) <i>12/30/98</i>				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>KIN K. WUN, 223 High St., Chestertown, MD 21620</i>								
31. Date filed (Month, Day, Year) <i>DEC 31 1998</i>		32. Registrar's Signature <i>Beverly B. Sparks</i>							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

1894/1895

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1894/1895

1894/1895

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 98 41326

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARGERY BLUMENAUER LANGE				2. Date of Death Month Day Year DECEMBER 24, 1998		3. Time of Death 7:15 A.M.		
	4a. Facility Name (If not institution, give street and number) 3605 BLANKENSHIP COURT				4b. City, Town, or Location of Death OLNEY		4c. County of Death MONTGOMERY		
Funeral Director	5. Social Security Number 215-48-1610		6. Sex 1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 51 Yrs.		8. Date of Birth (Month, Day, Year) OCT. 15, 1947		
	9. Birthplace (State or Foreign Country) WASHINGTON, D.C.		10a. State MARYLAND		10b. County MONTGOMERY		10c. City, Town or Location OLNEY		
10d. Inside City Limits 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 3605 BLANKENSHIP COURT		10f. Zip Code 20832		10g. Citizen of What Country? UNITED STATES OF AMERICA			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOME MAKER		16b. Kind of Business/Industry OWN HOME					
17. Father's Name (First, Middle, Last) THOMAS WILLIAM BLUMENAUER, Jr.				18. Mother's Name (First, Middle, Maiden Summa) JULIA ELIZABETH BISTLINE					
19a. Informant's Name/Relationship (Type, Print) ROBERT GEORGE LANGE (HUSBAND)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3605 BLANKENSHIP COURT OLNEY MARYLAND 20832					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) PARKLAWN MEMORIAL PARK		Date DEC. 29, 1998		20c. Location - City or Town, State ROCKVILLE MARYLAND			
21. Signature of Funeral Service Licensee James B. Schwartz				22. Name and Address of Facility HINES-RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVENUE SILVER SPRING MARYLAND 20904-2891					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. DECOMPENSATED LIVER DISEASE Due to (or as a consequence of):		30 DAYS					
		b. HEPATITIS CHRONIC Due to (or as a consequence of):		20 YEARS					
		c. _____ Due to (or as a consequence of):							
		d. _____ Due to (or as a consequence of):							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Nelson P. Trujillo, M.D.		29c. License number D10656		29d. Date signed (Month, Day, Year) DECEMBER 24, 1998			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NELSON P. TRUJILLO, M.D., 2021 K STREET, NW, WASHINGTON, D.C. 20006									
31. Date filed (Month, Day, Year) DEC 29 1998		32. Registrar's Signature Benita B. Sparks							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural," or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Muriel Sue Levine</b>					2. Date of Death Month <b>December</b> Day <b>28</b> Year <b>1998</b>		3. Time of Death <b>11:37 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>723 Wilson Avenue</b>					4b. City, Town, or Location of Death <b>Rockville</b>		4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>158-16-2116</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>74</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>July 18, 1924</b>		9. Birthplace (State or Foreign Country) <b>New York</b>
	Usual Residence of Decedent								
10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Rockville</b>				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10e. Street and Number <b>723 Wilson Avenue</b>					10f. Zip Code <b>20850</b>		10g. Citizen of What Country? <b>United States</b>		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) <b>5+</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Social Worker</b>			16b. Kind of Business/Industry <b>Chestnut Lodge</b>		
17. Father's Name (First, Middle, Last) <b>David Parker</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Theresa Sacks</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Bertram Levine/Husband</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>723 Wilson Avenue, Rockville, Maryland 20850</b>				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Norbeck Memorial Park</b>			Date <b>Dec. 31, 1998</b>		20c. Location - City or Town, State <b>Olney, Maryland</b>	
21. Signature of Funeral Service Licensee  <b>M00198</b>					22. Name and Address of Facility <b>Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									Approximate interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) <b>Carcinoma of the Ampulla of Vater</b>									<b>2 years</b>
Due to (or as a consequence of):									
Due to (or as a consequence of):									
Due to (or as a consequence of):									
Due to (or as a consequence of):									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Coronary Artery Disease</b> <b>Orthostatic Hypotension, Chronic</b>									23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier  <b>Joseph A. Romeo M.D.</b>					29c. License number <b>D09680</b>		29d. Date signed (Month, Day, Year) <b>December 28, 1998</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Joseph A. Romeo, M.D. 5454 Wisconsin Avenue, Chevy Chase, Maryland 20815</b>									
31. Date filed (Month, Day, Year) <b>DEC 30 1998</b>			32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be dated for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41328

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Joan Lawhorne Lewallen

2. Date of Death

December 19, 1998

3. Time of Death

11:50 P.M.

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

220-40-4086

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

54 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

March 1, 1944

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

127 Water Street

10f. Zip Code

20877

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.  
Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Collator

16b. Kind of Business/Industry

National  
Bureau of Affairs

17. Father's Name (First, Middle, Last)

Clarence Edward Lawhorne

18. Mother's Name (First, Middle, Maiden Surname)

Helen Floyd

19a. Informant's Name/Relationship (Type, Print)

Kenneth O. Lewallen/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

127 Water Street, Gaithersburg, MD. 20877

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Quantico National Cem.

Date

12/24/98

20c. Location - City or Town, State

Quantico, Virginia

Signature of Funeral Service Licensee

22. Name and Address of Facility

DeVol Funeral Home  
10 East Deer Park Dr., Gaithersburg, MD. 20877

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Contact Gunshot Wound of Head

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☒ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month Day Year)

12/19/98

28b. Time of Injury

Unknown

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Subject shot self

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Home: 127 Waters Street Gaithersburg, Md.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

127 Waters Street Gaithersburg, Md.

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of his knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

J. Pestaner, M.D.

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

December 20, 1998

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

Joseph Pestaner

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

DEC 28 1998

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

20th April

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 41329

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Helen H. Livingston

2. Date of Death

Month Day Year  
December 25, 1998

3. Time of Death

7:00 AM

4a. Facility Name (If not institution, give street and number)

Shady Grove Adventist Hospital

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

579-10-5116

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Feb. 25, 1909

9. Birthplace (State or Foreign Country)

New York, NY

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1235 Potomac Valley Road

10f. Zip Code

20850

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

18a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Administrator

16b. Kind of Business/Industry

Accounting

17. Father's Name (First, Middle, Last)

Samuel Mindel

18. Mother's Name (First, Middle, Maiden Surname)

Alice Gandel

19a. Informant's Name/Relationship (Type, Print)

Saul Mindel / Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3515 Tarkington Lane, Silver Spring, MD 20906

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Judean Memorial Gardens

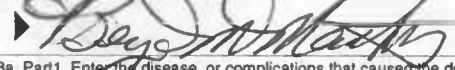
Date

Dec.

20c. Location - City or Town, State

Olney, Maryland

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Ives Pearson Funeral Home

2847 Wilson Blvd, Arlington, Va. 22201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardiopulmonary Arrest

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Immediate

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Depression

Chronic Urinary Tract Infections

Multi Infarct Dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ NoHospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D-38847

29d. Date signed (Month, Day, Year)

December 26, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David Klein, MD Medical Center Dr. Rockville, MD 20850

31. Date filed (Month, Day, Year)

DEC 30 1998

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

08 41330

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CARMELLIA LOUISE LONCKE

2. Date of Death

December 29 1998

3. Time of Death

3:00 PM

4a. Facility Name (If not institution, give street and number)

SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

132-09-9464

6. Sex

1 ☐ M ☒ F

7. Age (in yrs. last birthday)

84

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Apr 5, 1914

9. Birthplace (State or Foreign Country)

Jamaica

Usual Residence of Decedent

10a. State

Md

10b. County

Montgomery

10c. City, Town or Location

North Potomac

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

15828 Seurat Drive

10f. Zip Code

20878

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2 Yrs

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Office

17. Father's Name (First, Middle, Last)

Joseph A. King

18. Mother's Name (First, Middle, Maiden Surname)

Isadora L. Dawson

19a. Informant's Name/Relationship (Type, Print)

Linda E. Lightfoot (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

15828 Seurat Dr, N. Potomac, Md 20878

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Key, s Funeral Home

Date

1/3/99

20c. Location - City or Town, State

New Haven, Conn

Signature of Funeral Service Licensee

*George R. Snowden*

22. Name and Address of Facility

Snowden Funeral Home P.A. 20850  
246 N. Washington St., Rockville, Md

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

*Chronic obstructive pulmonary disease*

Approximate Interval Between Onset and Death

*years*

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*Pneumonia*

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*Alan J. Chanale*

29c. License number

294453

29d. Date signed (Month, Day, Year)

December 29, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ALAN J. CHANALE 15225 SHADY GROVE RD ROCKVILLE MD 20850

31. Date filed (Month, Day, Year)

DEC 31 1998

32. Registrar's Signature

*Benita B. Sparks*State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEMS: #1 PER MD G776 10-16-99 **Certificate of Death**

Reg. No.

98 41331

<b>Physician /Medical Examiner</b>	1. Decedant's Name (First, Middle, Last) <b>Helen Harris Lessahn HELEN HARRIS LASSAHN</b>					2. Date of Death Month <b>December</b> Day <b>18</b> , Year <b>1998</b>		3. Time of Death <b>3:15p.m.</b>		
	4e. Facility Name (If not Institution, give street and number) <b>Heron Point</b>					4b. City, Town, or Location of Death <b>Chestertown</b>		4c. County of Death <b>Kent</b>		
<b>Funeral Director</b>	5. Social Security Number <b>215-16-8959</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>83</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>August 7, 1915</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedant									
<b>To Be Completed by Funeral Director</b>	10e. State <b>Maryland</b>		10b. County <b>Kent</b>		10c. City, Town or Location <b>Chestertown</b>				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number <b>2003 Heron Point</b>					10f. Zip Code <b>21620</b>		10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedant Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedant of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
	15. Decedant's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> Collage (1-4 or 5+)			16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Supervisor of Recreation Dept.</b>			16b. Kind of Business/Industry <b>Baltimore Dept. of Parks and Recreation</b>			
	17. Father's Name (First, Middle, Last) <b>Arthur L. Harris</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Evelyn Bockmiller</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>Anne Weber/Neice</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>235 Leppo Road, Westminster, MD 21158</b>				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Dulaney Valley Cemetery</b>		Data <b>12/23/98</b>		20c. Location - City or Town, State <b>Timonium, Maryland</b>			
	21. Signature of Funeral Service Licensee 					22. Name and Address of Facility <b>Fellows, Helfenbein &amp; Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, MD 21620</b>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. END STAGE ALZHEIMERS DISEASE</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death.) Last <b>b.</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b> Due to (or as a consequence of):									
	Approximate Interval Between Onset and Death <b>&gt;10yrs.</b>									
<b>Physician /Medical Examiner</b>	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown									
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicida 4 <input type="checkbox"/> Homicida		28e. Date of Injury (Month, Day Year)		28b. Time of injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	29b. Signature and title of certifier 					29c. License number <b>D41587</b>		29d. Date signed (Month, Day, Year) <b>12/21/98</b>		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Helen A. Noble 122 Speer Road, Suite 5, Chestertown, MD 21620</b>									
	31. Date filed (Month, Day, Year) <b>DEC 23 1998</b>		32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41332

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Bessie Lea Lurkins</b>				2. Date of Death Month Day Year <b>Dec 27 1998</b>				3. Time of Death <b>9:00pm</b>	
	4e. Facility Name (If not institution, give street and number) <b>Lorien Nursing Center</b>				4b. City, Town, or Location of Death <b>Columbia</b>				4c. County of Death <b>Howard</b>	
Funeral Director	5. Social Security Number <b>111-32-1971</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>99</b>		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) <b>Jan 18 1899</b>		9. Birthplace (State or Foreign Country) <b>MD</b>		Usual Residence of Decedent					
To Be Completed by Funeral Director	10a. State <b>Md</b>		10b. County <b>Howard</b>		10c. City, Town or Location <b>Jessup</b>				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>10045 Guilford Road</b>				10f. Zip Code <b>20794</b>		10g. Citizen of What Country? <b>USA</b>			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>black</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5+)				16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>nurse maid</b>				16b. Kind of Business/Industry <b>Children's Nursery</b>	
	17. Father's Name (First, Middle, Last) <b>John Dorsey</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Leanna</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Albert Leroy Young (nephew)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10045 Guilford Rd. Jessup, MD 20794</b>					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Bushey Park Cemetery</b>		Date <b>12-31-98</b>		20c. Location - City or Town, State <b>Cooksville, MD</b>	
	21. Signature of Funeral Service Licensee <b>Brian L. Haight</b>				22. Name and Address of Facility <b>Haight Funeral Home &amp; Chapel</b> <b>P.O. Box 195 Sykesville, MD 21784</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  e. <b>Severe Metabolic Acidosis</b> Due to (or as a consequence of): b. <b>Renal Failure</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hypervatremia</b>				Approximate Interval Between Onset and Death					
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28e. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how Injury occurred				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <b>[Signature]</b>				29c. License number <b>D40413</b>		
29d. Date signed (Month, Day, Year) <b>12/28/98</b>				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>2 Knoll N. Drive Columbia, MD 21045</b>				DR. MARGUERITE SOMMERS		
31. Date filed (Month, Day, Year) <b>DEC 30 1998</b>				32. Registrar's Signature <b>[Signature]</b>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



State of Maryland / Department of Health and Mental Hygiene 98 41333

## Certificate of Death

Reg. No.

DMMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41334

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Mary Ann Kelling Markwell</b>				2. Date of Death Month <b>December</b> Day <b>21</b> , Year <b>1998</b>		3. Time of Death <b>2143</b>	
	4a. Facility Name (If not Institution, give street and number) <b>6705 Rockledge Drive</b>				4b. City, Town, or Location of Death <b>Bethesda</b>		4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>273-46-7817</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>50</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>September 30, 1948</b>	9. Birthplace (State or Foreign Country) <b>Ohio</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Bethesda</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>4977 Battery Lane, #512</b>				10f. Zip Code <b>20814</b>		10g. Citizen of What Country? <b>United States</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>-</b> College (1-4or 5+) <b>5+</b>				16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Health Science Administrator</b>			16b. Kind of Business/Industry <b>N.I.H.</b>	
17. Father's Name (First, Middle, Last) <b>Aloysius Kelling</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Lucille Neumann</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Gary Diamond/Personal Rep.</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2815 University Blvd.W., Kensington, MD 20895</b>			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Montgomery Crematorium, Inc.</b>			20c. Location - City or Town, State <b>Bethesda, Maryland</b>		
21. Signature of Funeral Service Licensee  <b>M00689</b>			22. Name and Address of Facility <b>Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Gunshot wound to head</b> Due to (or as a consequence of):  Sequitely list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death <b>seconds</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify)					
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year) <b>December 21, 1998</b>		28b. Time of Injury <b>2143 hrs.</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
			28e. Piece of Injury - At home, term, street, factory, office building, etc. (Specify) <b>parking lot</b>		28d. Describe how injury occurred <b>Self-inflicted gunshot wound</b>			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner			29c. License number <b>D 51916</b>					
29b. Signature and title of certifier <b>Patricia L. Tomsko, MD</b>			29d. Date signed (Month, Day, Year) <b>December 21, 1998</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Patricia L. Tomsko, MD, 11140 Rockville Pike, #348, Rockville, MD 20852</b>								
31. Date filed (Month, Day, Year) <b>DEC 30 1998</b>			32. Registrar's Signature 					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

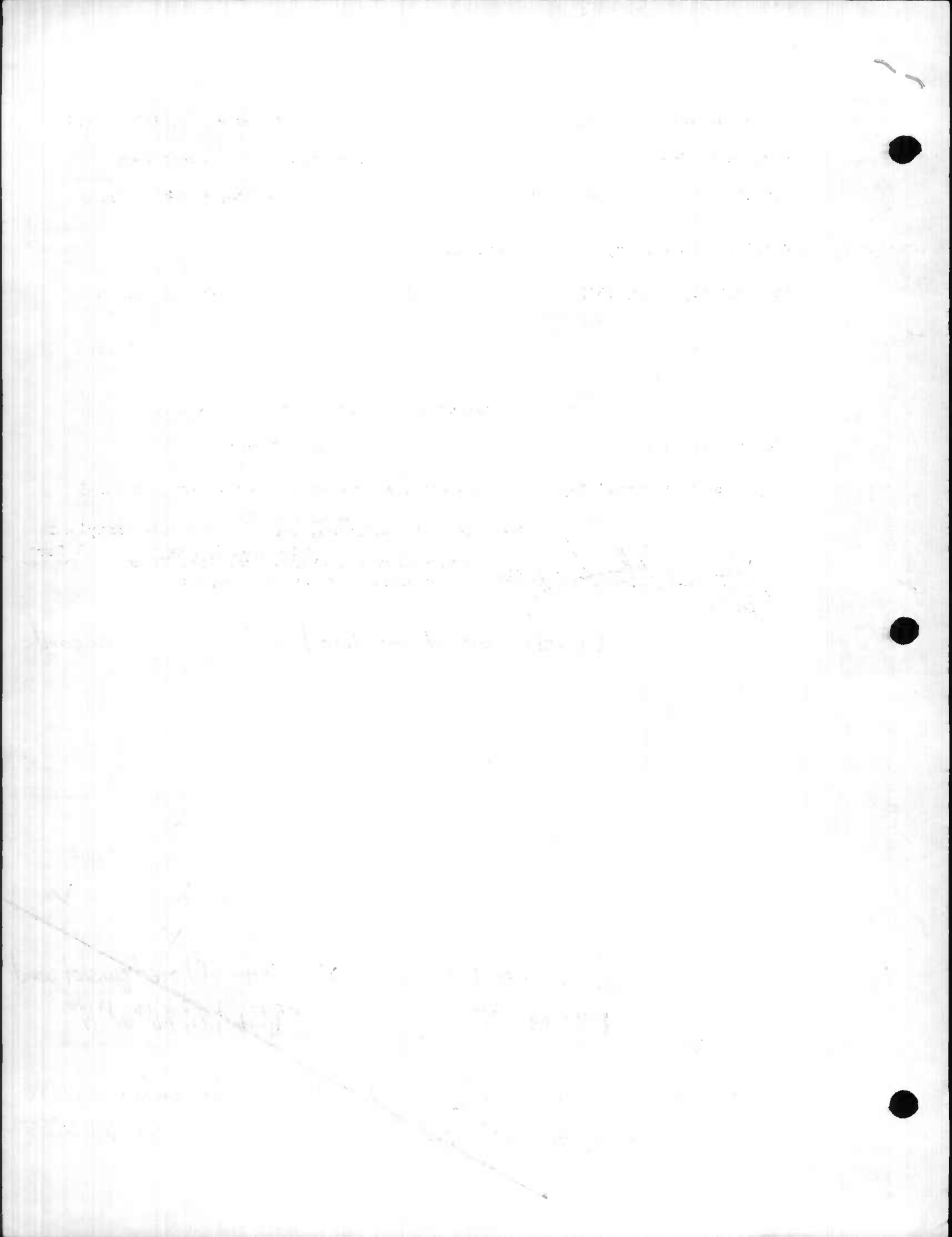
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

88 41335

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) <b>German Amilcar Martinez</b>						2. Date of Death Month Day Year <b>December 26, 1998</b>		3. Time of Death <b>1:00 PM</b>		
4a. Facility Name (If not institution, give street and number) <b>Washington Adventist Hospital</b>						4b. City, Town, or Location of Death <b>Takoma Park</b>		4c. County of Death <b>Montgomery</b>		
5. Social Security Number <b>213-31-2121</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>45</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Oct. 19, 1953</b>		9. Birthplace (State or Foreign Country) <b>El Salvador</b>		
Usual Residence of Decedent										
10a. State <b>MD</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Chevy Chase</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>3703 Chevy Chase Lake Drive, #1</b>				10f. Zip Code <b>20815</b>		10g. Citizen of What Country? <b>El Salvador</b>				
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify: <b>El Salvadorian</b>			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Maintenance Engineer</b>			16b. Kind of Business/Industry <b>Montgomery County Schools</b>			
17. Father's Name (First, Middle, Last) <b>Miguel Angel Martinez</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Felipa Torres</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Anna Gloria Martinez (wife)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>20815 3703 Chevy Chase Lake Drive, #1, Chevy Chase, MD</b>						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gate of Heaven Cemetery</b>		Date <b>12/30/98</b>		20c. Location - City or Town, State <b>Silver Spring, MD</b>				
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Cerebral hemorrhage</b> Due to (or as a consequence of):  Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>										Approximate Interval Between Onset and Death <b>2 Days</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Acquired Immunodeficiency Syndrome</b> <b>Renal failure</b>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier 				29c. License number <b>D45660</b>		29d. Date signed (Month, Day, Year) <b>12-27-98</b>				
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Dpinder Singh 14300, GALLANT FOX LN, Bowie MD 20715</b>										
31. Date filed (Month, Day, Year) <b>DEC 28 1998</b>				32. Registrar's Signature 						

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
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Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41336

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Mary Kyne Maze

2. Date of Death

Dec 23 1998

3. Time of Death

9:26 AM

4a. Facility Name (If not institution, give street and number)

Surburan Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

5. Social Security Number

022-20-4001

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

69 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

05-18-1929

9. Birthplace (State or Foreign Country)

Ma

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6210 Rockhurst Road

10f. Zip Code

20817

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

5yrs +

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Teacher

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Peter Kyne

18. Mother's Name (First, Middle, Maiden Surname)

Mary E. Lydon

19a. Informant's Name/Relationship (Type, Print)

Chester Maze (Husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6210 Rockhurst Rd. Bethesda, Md. 20817

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☒ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Georgetown Med School 12/24/98 Wash, D.C.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Austin Royster Funeral Home

3821 14th St. N.W. Wash, D.C. 20011

23a. Part I. Enter on disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Asthma  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

David Holden MD

29c. License number

P47791

29d. Date signed (Month, Day, Year)

December 23, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

809 Veirs Mill Rd, Rockville MD

20851 - David Holden MD

State  
Registrar

31. Date filed (Month, Day, Year)

DEC 29 1998

32. Registrar's Signature

Jennifer B. Sparks

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41337

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Joseph B. McCully				2. Date of Death Month Day Year December 29, 1998		3. Time of Death 8:35 PM													
	4a. Facility Name (If not institution, give street and number) Montgomery Village and Rehabilitation				4b. City, Town, or Location of Death Montgomery Village		4c. County of Death Montgomery													
Funeral Director	5. Social Security Number 577-09-6039		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 81 Yrs.		8. Date of Birth (Month, Day, Year) April 15, 1917													
	9. Birthplace (State or Foreign Country) Washington, DC		10a. State MD		10b. County Montgomery		10c. City, Town or Location Montgomery Village													
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 19310 Clubhouse Road, Apt. 314		10f. Zip Code 20886		10g. Citizen of What Country? USA														
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1943-46		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White														
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) General Foreman		16b. Kind of Business/Industry PEPCO																
17. Father's Name (First, Middle, Last) Hugh McCully				18. Mother's Name (First, Middle, Maiden Surname) Nancy Abel																
19a. Informant's Name/Relationship (Type, Print) Marie B. McCully (wife)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20886 19310 Clubhouse Road, Apt. 314, Montgomery Village, MD																
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery		20c. Location - City or Town, State Silver Spring, MD		20d. Date 1/2/99														
21. Signature of Funeral Service Licensee Steven D. Strand				22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901																
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																				
<table border="1"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a.</td> <td>Metastatic Renal Cell Carcinoma</td> <td>Approximate Interval Between Onset and Death 6 months</td> </tr> <tr> <td>b.</td> <td>Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>c.</td> <td>Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d.</td> <td>Due to (or as a consequence of):</td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	Metastatic Renal Cell Carcinoma	Approximate Interval Between Onset and Death 6 months	b.	Due to (or as a consequence of):		c.	Due to (or as a consequence of):		d.	Due to (or as a consequence of):	
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	Metastatic Renal Cell Carcinoma	Approximate Interval Between Onset and Death 6 months																	
	b.	Due to (or as a consequence of):																		
	c.	Due to (or as a consequence of):																		
	d.	Due to (or as a consequence of):																		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. non insulin dependent diabetes mellitus  Coronary artery disease						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown														
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No														
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)																
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																				
29b. Signature and title of certifier Dr. [Signature] MD				29c. License number D33443		29d. Date signed (Month, Day, Year) December 30, 1998														
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Abn R. Pollock, M.D. 809 Viers Mill Rd Rockville, MD 20851																				
31. Date filed (Month, Day, Year) DEC 31 1998		32. Registrar's Signature [Signature]																		

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

10+1





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Catherine McKenna

2. Date of Death

December 29, 1998

3. Time of Death

1:05 PM

4a. Facility Name (If not institution, give street and number)

12906 Forest View Drive

4b. City, Town, or Location of Death

Beltsville

4c. County of Death

Prince Georges

Funeral  
Director

5. Social Security Number

578-12-6923

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Nov. 19, 1914

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

MD

10b. County

Prince Georges

10c. City, Town or Location

Beltsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

12906 Forest View Drive

10f. Zip Code

20705

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Teacher

16b. Kind of Business/Industry

Education

17. Father's Name (First, Middle, Last)

John J. Donnellan

18. Mother's Name (First, Middle, Maiden Surname)

Mary Agnes Mulhall

19a. Informant's Name/Relationship (Type, Print)

Denis D. McKenna (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12906 Forest View Drive, Beltsville, MD 20705

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

1/2/99

20c. Location - City or Town, State

Silver Spring, MD

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Francis J. Collins Funeral  
Home, Inc. 500 University Blvd. West  
Silver Spring, MD 2090123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Lymphoma

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No

25. Was case referred to medical

examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending

Investigation

2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be

determined

28e. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

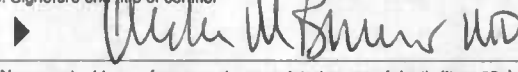
Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29e. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier



29c. License number

D31563

29d. Date signed (Month, Day, Year)

December 30, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charles M. Benner, M.D., 11251 Lockwood Drive, Silver Spring, MD 20901

State  
Registrar

31. Date filed (Month, Day, Year)

DEC 31 1998

32. Registrar's Signature



Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

08 41339

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Martha Jane Miller				2. Date of Death Month: December Day: 29, Year: 1998		3. Time of Death 2:10 PM	
	4a. Facility Name (If not institution, give street and number) Shady Grove Adventist Hospital				4b. City, Town, or Location of Death Rockville		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 211-14-7896		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 78 Yrs.		8. Date of Birth (Month, Day, Year) May 2, 1920	
	9. Birthplace (State or Foreign Country) Pennsylvania		10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Damascus	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number 10615 Hunters Chase Lane		10f. Zip Code 20872	
	10g. Citizen of What Country? United States				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collega (1-4or 5+) 4	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry Own Home		17. Father's Name (First, Middle, Last) David Harold McGee	
To Be Completed by Physician/Medical Examiner	18. Mother's Name (First, Middle, Maiden Surname) Martha Susan Stouffer				19a. Informant's Name/Relationship (Type, Print) H. George Miller (husband)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as 10	
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory		20c. Location - City or Town, State 12-30-98 Beltsville, Maryland	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee Ellen H. Rapp				22. Name and Address of Facility Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Anoxic Encephalopathy Due to (or as a consequence of): b. Pulmonary Edema Due to (or as a consequence of): c. Pulmonary Fibrosis Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death 24 hours 24 hours 4 years			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 28d. Describe how injury occurred			
To Be Completed by Physician/Medical Examiner	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier A.P. KURUVILLA, M.D.			
To Be Completed by Physician/Medical Examiner	29c. License number D 46187				29d. Date signed (Month, Day, Year) December 30, 1998			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ajit P. Kuruvilla, M. D., 11125 Rockville Pike, Rockville, MD 20852				31. Date filed (Month, Day, Year) DEC 31 1998			
To Be Completed by Physician/Medical Examiner	32. Registrar's Signature B. Sparks				33. Date of Death December 29, 1998			
	34. Date of Death December 29, 1998				35. Date of Death December 29, 1998			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41340

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Eugene Patrick Moody</b>				2. Date of Death Month Day Year <b>December 26, 1998</b>		3. Time of Death <b>1754</b>	
	4a. Facility Name (If not institution, give street and number) <b>Washington Adventist Hospital</b>				4b. City, Town, or Location of Death <b>Takoma Park</b>		4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>082-24-4948</b>		6. Sex <b>1 M 2 F</b>		7. Age (In yrs. last birthday) <b>66</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>August 10, 1932</b>	
	9. Birthplace (State or Foreign Country) <b>North Carolina</b>		10a. State <b>MD</b>		10b. County <b>Prince Georges</b>		10c. City, Town or Location <b>Hyattsville</b>	
Usual Residence of Decedent		10d. Inside City Limits <b>1 Yes 2 No</b>		10e. Street and Number <b>4907 Eastern Avenue, #212</b>		10f. Zip Code <b>20782</b>		
10g. Citizen of What Country? <b>USA</b>		11. Marital Status <b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>1 Yes 2 No</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No) <b>1 Yes 2 No</b>		
14. Race - American Indian, Black, White, etc. <b>White</b>		15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 3</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Systems Programmer Analyst</b>		16b. Kind of Business/Industry <b>Computer</b>		
17. Father's Name (First, Middle, Last) <b>Eugene Patrick Moody</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Julia Schmitt</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Tiane B. Moody (daughter)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8905 Barrowgate Court, Potomac, MD 20854</b>				
20a. Method of Disposition <b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metropolitan Crematory</b>		20c. Location - City or Town, State <b>1/2/98 Alexandria, VA</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Arteriosclerotic Cardiovascular Disease</b>								
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
23c. Did tobacco use contribute to the cause of death? <b>1 Yes 2 No 3 Probably 4 Unknown</b>								
24a. Was an autopsy performed? <b>1 Yes 2 No</b>								
24b. Were autopsy findings available prior to completion of cause of death? <b>1 Yes 2 No</b>								
25. Was case referred to medical examiner? <b>1 Yes 2 No</b>								
26. Place of Death (Check only one) Hospital: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> Other: <b>4 Nursing Home 5 Residence 8 Other (Specify)</b>								
27. Manner of Death <b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined</b>								
28a. Date of Injury (Month, Day, Year) <b>28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No</b>								
28d. Describe how injury occurred								
28e. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <b>1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>								
29b. Signature and title of certifier 								
29c. License number <b>D15236</b>								
29d. Date signed (Month, Day, Year) <b>December 29, 1998</b>								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Carl I. Margolis, M.D. 11125 Rockville Pike, Rockville, MD 20852</b>								
31. Date filed (Month, Day, Year) <b>DEC 31 1998</b>								
32. Registrar's Signature 								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Paul Joseph Moore</b>				2. Date of Death Month <b>Dec</b> Day <b>24</b> Year <b>1998</b>		3. Time of Death <b>1040</b>	
	4a. Facility Name (If not institution, give street and number) <b>8407 Piney Branch Rd.</b>				4b. City, Town, or Location of Death <b>Silver Spring</b>		4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>579-09-1463</b>		6. Sex <b>1</b> M <b>2</b> F	7. Age (In yrs. last birthday) <b>83</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Sept. 15, 1915</b>	9. Birthplace (State or Foreign Country) <b>New York</b>
	Usual Residence of Decedent							
10a. State <b>MD</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Silver Spring</b>			10d. Inside City Limits <b>1</b> Yes <b>2</b> No	
10e. Street and Number <b>8407 Piney Branch Road</b>				10f. Zip Code <b>20901</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <b>1</b> Never Married <b>2</b> Married <b>3</b> Widowed <b>4</b> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <b>1</b> Yes <b>2</b> No If Yes, Give Year or Dates: <b>1943-44</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> Yes <b>2</b> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Engineer</b>		16b. Kind of Business/Industry <b>Government</b>		
17. Father's Name (First, Middle, Last) <b>George Moore</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Gertrude Hill</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Helen Moore (wife)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8407 Piney Branch Road, Silver Spring, MD 20901</b>				
20a. Method of Disposition <b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State <b>4</b> Donation <b>5</b> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metropolitan Crematory</b>		Date <b>12/25/98</b>		20c. Location - City or Town, State <b>Alexandria, Virginia</b>		
21. Signature of Funeral Service Licensee <b>Tracey A. Spencer</b>				22. Name and Address of Facility <b>Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>myocardial Infarction</b> Due to (or as a consequence of): b. <b>ASCVD</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death <b>DME</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown
24a. Was an autopsy performed? <b>1</b> Yes <b>2</b> No								24b. Were autopsy findings available prior to completion of cause of death? <b>1</b> Yes <b>2</b> No
25. Was case referred to medical examiner? <b>1</b> Yes <b>2</b> No				26. Place of Death (Check only one) Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify)				
27. Manner of Death <b>1</b> Natural <b>5</b> Pending investigation <b>2</b> Accident <b>6</b> Could not be determined <b>3</b> Suicide <b>4</b> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <b>1</b> Yes <b>2</b> No		28d. Describe how injury occurred
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <b>1</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <b>Dr. B. Baker M.D. DME</b>		29c. License number <b>D00428</b>		29d. Date signed (Month, Day, Year) <b>Dec 24, 1998</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>IRB N. GRECHER, MD DME</b>				<b>2101 Medical Park Dr Silver Spring, MD, 20902</b>				
31. Date filed (Month, Day, Year) <b>DEC 28 1998</b>				32. Registrar's Signature <b>B. Sparks</b>				

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1041





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41342

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Francine Moss

2. Date of Death

December 27, 1998

3. Time of Death

5:20 AM

4a. Facility Name (If not institution, give street and number)

Brighton Gardens

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

5. Social Security Number

082-14-6522

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79

8. Data of Birth

Dec. 12, 1919

9. Birthplace (State or Foreign Country)

New York City

Usual Residence of Decedent

10e. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5555 Friendship Blvd.

10f. Zip Code

20016

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Philip Vogelmann

18. Mother's Name (First, Middle, Maiden Surname)

Thelma Lieberman

19a. Informant's Name/Relationship (Type, Print)

Morton Moss / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1208 Old Stable Rd. McLean Va. 22102

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory

Date

Dec.

27, 1998

20c. Location - City or Town, State

Alexandria Va.

21. Signature of Funeral Service Licensee

*[Signature]*

22. Name and Address of Facility

Ives Pearson Funeral Home  
472 N. Washington St. Falls Church, Va. 22046

23a. Paper, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastasis to brain

Due to (or as a consequence of):

months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Lung Carcinoma

Due to (or as a consequence of):

months

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

*[Signature]* Dr. [Name]

29c. License number

D31319

29d. Date signed (Month, Day, Year)

12-27-1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Love to ALBIOL MD 8218 Wisconsin Ave #103 Bethesda, MD

31. Date filed (Month, Day, Year)

DEC 30 1998

32. Registrar's Signature

*[Signature]* B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Samuel Adam Moss

2. Date of Death  
Month Day Year  
December 27, 1998

3. Time of Death  
9:25am

4a. Facility Name (If not institution, give street and number)

Shady Grove Adventist Hospital

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

183-07-6608

6. Sex  
1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

100

If Under 1 Year  
Months Days

If Under 24 Hrs.  
Hours Min.

8. Date of Birth  
(Month, Day, Year)

Jan. 25, 1898

9. Birthplace (State or Foreign Country)

London, England

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits  
1 ☐ Yes 2 ☒ No

10e. Street and Number

1 Pueblo Court

10f. Zip Code

20878

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.  
Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Butcher

16b. Kind of Business/Industry

Meat

17. Father's Name (First, Middle, Last)

Hyman Moss

18. Mother's Name (First, Middle, Maiden Surname)

Bell Cohen

19a. Informant's Name/Relationship (Type, Print)

Mildred Diamond (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1 Pueblo Court, Gaithersburg, MD 20878

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Metropolitan Crematory 12/28/98

Date

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

22. Name and Address of Facility DeVol Funeral Home  
10 East Deer Park Drive  
Gaithersburg, MD 20877

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.

Immediate Cause (Final  
disease or condition  
resulting in death)

a. Sepsis

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

2 Days

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Recurrent Seizures, Diabetes Mellitus, Dementia,

Bullous Pemphigoid

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy  
performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings  
available prior to  
completion of cause  
of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury  
(Month, Day, Year)

28b. Time of  
Injury

28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)

29a. Certifier  
(Check only  
one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D42403

29d. Date signed (Month, Day, Year)

December 28, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Raj Mathur, M.D. 106 Irving Street, Washington, DC 20010

31. Date filed (Month, Day, Year)

DEC 31 1998

32. Registrar's Signature

*Renata B. [Signature]*

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41344

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Paul Eugene Maldeis

2. Date of Death  
Month Day Year

Dec. 26, 1998

3. Time of Death  
2:15am

4a. Facility Name (If not institution, give street and number)

6143 Forest Lane

4b. City, Town, or Location of Death

Eldersburg

4c. County of Death

Carroll

Funeral  
Director

5. Social Security Number

213-68-2465

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

44 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

Aug 14, 1954

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Carroll

10c. City, Town or Location

Eldersburg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6143 Forest Lane

10f. Zip Code

21784

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

3

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Systems Analyst

16b. Kind of Business/Industry

Computer Science

17. Father's Name (First, Middle, Last)

Walter Maldeis

18. Mother's Name (First, Middle, Maiden Surname)

Doris Croop

19a. Informant's Name/Relationship (Type, Print)

Mrs. Nancy E. Maldeis (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6143 Forest Lane Eldersburg, MD 21784

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Carroll Cremation Serv.

Date

12/29/98 Hampstead, MD

21. Signature of Funeral Service Licensee

Brian A. Haight

22. Name and Address of Facility

HAIGHT FUNERAL HOME & CHAPEL (Box 195)  
Sykesville, MD 21784 (410)-795-1400

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. RESPIRATORY FAILURE

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. RECURRENT PULMONARY INFECTIONS &amp; FIBROSIS

Due to (or as a consequence of):

YEARS

c. AGAMMA GLOBULINEMIA

Due to (or as a consequence of):

YEARS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined28a. Date of Injury  
(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Jay Gerstenblith, MD

29c. License number

D20724

29d. Date signed (Month, Day, Year)

Dec. 28, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Jay Gerstenblith, M.D. St. Agnes Hospital, Baltimore, MD 21229

31. Date filed (Month, Day, Year)

DEC 30 1998

32. Registrar's Signature

Beverly B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) <b>ELEANORA ROSS MORGAN</b>						2. Date of Death Month Day Year <b>Dec., 22, 1998</b>		3. Time of Death <b>10:40AM</b>	
4a. Facility Name (If not institution, give street and number) <b>HOSPICE HOUSE</b>						4b. City, Town, or Location of Death <b>EASTON</b>		4c. County of Death <b>TALBOT</b>	
5. Social Security Number <b>218-03-0448</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (in yrs. last birthday) <b>94</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>AUG. 22, 1904</b>		9. Birthplace (State or Foreign Country) <b>MARYLAND</b>	
Usual Residence of Decedent									
10a. State <b>MARYLAND</b>		10b. County <b>TALBOT</b>		10c. City, Town or Location <b>ST. MICHAELS</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10e. Street and Number <b>112 MILES LANE, UNIT 122</b>				10f. Zip Code <b>21663</b>		10g. Citizen of What Country? <b>U.S.</b>			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4or 5+) <b>-0-</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>SEAMSTRESS</b>			16b. Kind of Business/Industry <b>GARMENT</b>		
17. Father's Name (First, Middle, Last) <b>THOMAS J. ROSS</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>SARAH E. HARRISON</b>			
19a. Informant's Name/Relationship (Type, Print) <b>ELVA JOAN MORGAN / DAUGHTER</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>112 MILES LANE, UNIT 122 ST. MICHAELS, MD. 21663</b>					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>ST. JOHN'S CEMETERY</b>		Date <b>12-28-98</b>		20c. Location - City or Town, State <b>TILGHMAN, MD.</b>	
21. Signature of Funeral Service Licensee <b>M. E. Newnam III CFSP</b>				22. Name and Address of Facility <b>FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME 200 S. HARRISON ST. EASTON, MD. 21601</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Unstable Angina</b> Due to (or as a consequence of): <b>b. Advanced Coronary Artery Disease</b> Due to (or as a consequence of): <b>c. Atherosclerotic Cardiovascular Ds.</b> Due to (or as a consequence of): <b>d. Hypertension</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Congestive heart Failure</b> <b>Chronic obstructive pulmonary Ds.</b>									
23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown									
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>HOSPICE</b>							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Russell Schilling</b>				29c. License number <b>H-42587</b>		29d. Date signed (Month, Day, Year) <b>Dec. 22, 1998</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Russell Schilling; 2540 Centreville Rd.; Centreville, Md. 21617</b>									
31. Date filed (Month, Day, Year) <b>DEC 28 1998</b>				32. Registrar's Signature <b>B. Sparks</b>					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ANNE ADAIR NEWTON</b>				2. Date of Death Month Day Year <b>DEC 28 1998</b>		3. Time of Death <b>11:30 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>NATIONAL NAVAL MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>BETHESDA</b>		4c. County of Death <b>MONTGOMERY</b>	
Funeral Director	5. Social Security Number <b>559-14-7641</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>80</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>January 24, 1918</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Bethesda</b>	
To Be Completed by Funeral Director	Usual Residence of Decedent				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	10e. Street and Number <b>9510 Kentstone Drive</b>				10f. Zip Code <b>20817</b>		10g. Citizen of What Country? <b>United States</b>	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>1</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Office Administrator</b>		16b. Kind of Business/Industry <b>National Institutes of Health</b>			
	17. Father's Name (First, Middle, Last) <b>Garnett Y. Clark</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Helen Hunt</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>John H. Newton/Husband</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9510 Kentstone Drive, Bethesda, Maryland 20817</b>			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Montgomery Crematorium, Inc.</b>		20c. Location - City or Town, State <b>Bethesda, Maryland</b>			
	21. Signature of Funeral Service Licensee <i>[Signature]</i> <b>M00846</b>		22. Name and Address of Facility <b>Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>STROKE</b> Due to (or as a consequence of):  b. <b>PNEUMONIA</b> Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
Physician /Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and title of certifier <i>[Signature]</i> <b>Sharon Reed MD</b>				29c. License number <b>RES-000</b>		29d. Date signed (Month, Day, Year) <b>12/29/98</b>	
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>SHARON REED, LT, MC, USNR</b>				31. Date filed (Month, Day, Year) <b>DEC 30 1998</b>			
	32. Registrar's Signature <i>[Signature]</i> <b>G. Sparks</b>				33. Date of Death <b>DEC 28 1998</b>			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

AMENDED #5, 01/06/99, L.A.P., Q.A. County

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Katherine Mary Nash

2. Date of Death

Month  
12Day  
16Year  
98

3. Time of Death

8:40 PM

4a. Facility Name (If not institution, give street and number)

CAROLINE NURSING HOME, INC.

4b. City, Town, or Location of Death

DENTON

4c. County of Death

CAROLINE

Funeral  
Director

5. Social Security Number

218-14-4274  
214-36-6170

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
Aug. 14, 1912

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Caroline

10c. City, Town or Location

Denton

10d. Inside City Limits

1 ☐ Yes 2 ☐ No

10e. Street and Number

25272 Pealiquor Road

10f. Zip Code

21629

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Self

17. Father's Name (First, Middle, Last)

Andrew Reese

18. Mother's Name (First, Middle, Maiden Summa)

Louise Marie Lettau

19a. Informant's Name/Relationship (Type, Print)

Katherine Kemp Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

25272 Pealiquor Road, Denton, MD 21629

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Woodlawn Memorial Park

Data

Dec. 19, 1998

20c. Location - City or Town, State

Easton, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Fellows, Helfenbein & Newnam Funeral Home, P.A.  
106 Shamrock Road, Chester, MD 21619

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia  
Due to (or as a consequence of):

Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.   
Due to (or as a consequence of):c.   
Due to (or as a consequence of):d.   
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

dementia

non insulin dependant diabetes mellitus

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

M.D.

29c. License number

D47534

29d. Date signed (Month, Day, Year)

12/17/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHORE CLINICAL FOUNDATION 920 MARKET STREET DENTON, MARYLAND 21629

State  
Registrar

31. Date filed (Month, Day, Year)

DEC 22 1998

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41348

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

SAUL OLIN

2. Date of Death

12/26/98

3. Time of Death

9:20AM

4a. Facility Name (If not institution, give street and number)

Arden Courts Assisted Living Center

4b. City, Town, or Location of Death

Potomac

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

153 26 4227

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

100 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

09-18-1898

9. Birthplace (State or Foreign Country)

Russia

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Potomac

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10a. Street and Number

11902 Milbern Drive

10f. Zip Code

20854

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married

3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Self Employed

16b. Kind of Business/Industry

Retail Goods

17. Father's Name (First, Middle, Last)

Israel Olin

18. Mother's Name (First, Middle, Maiden Surname)

Unknown

19a. Informant's Name/Relationship (Type, Print)

Erwin Olin Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11902 Milbern Dr, Potomac, MD 20854

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Park Cemetery

Date

12-29-1998

20c. Location - City or Town, State

PARAMUS, New Jersey

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Danzansky-Goldberg Memorial Chapel, Inc

1170 Rockville Pike, Rockville, MD 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

4 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural

2 ☐ Accident

3 ☐ Suicide

4 ☐ Homicide

5 ☐ Pending investigation

6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Danzansky-Goldberg

29c. License number

D292229

29d. Date signed (Month, Day, Year)

12/27/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Martin S. Kanorsky, MD 5530 Wisconsin Ave #730 Chevy Chase MD 20815

31. Date filed (Month, Day, Year)

DEC 29 1998

32. Registrar's Signature

Beverly B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

08 41349

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Charlotte Otto				2. Date of Death Month Day Year Dec. 12 1998		3. Time of Death 8:20 PM	
	4a. Facility Name (If not institution, give street and number) Shore Nursing & Rehabilitation Center				4b. City, Town, or Location of Death Denton		4c. County of Death Caroline	
Funeral Director	5. Social Security Number 155-36-9939		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 96 Yrs.		8. Date of Birth (Month, Day, Year) Aug. 27, 1902	
	9. Birthplace (State or Foreign Country) Germany		10a. State NJ		10b. County Bergen		10c. City, Town or Location Demarest	
To Be Completed by Funeral Director	Usual Residence of Decedent				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	10e. Street and Number 41 Blanche Avenue				10f. Zip Code 07627		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Self			
	17. Father's Name (First, Middle, Last) Georg Wilm				18. Mother's Name (First, Middle, Maiden Surname) Emma Wolf			
	19a. Informant's Name/Relationship (Type, Print) Erika Edith Roof Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 120 Congressional Drive, Stevensville, MD 21666			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) George Washington Memorial Cem.		Date Dec. 18, 1998		20c. Location - City or Town, State Paramus, NJ	
	21. Signature of Funeral Service Licensee <i>Amato Michiewicz</i>				22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 106 Shamrock Road, Chester, MD 21619			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pneumonia Due to (or as a consequence of): Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Anorexia				Approximate Interval Between Onset and Death 1 wk			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Anorexia				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		
28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Dr. J. Spruill</i>		29c. License number 032036		29d. Date signed (Month, Day, Year) 12/14/98		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Gary J. Spruill 210P N. Durak Drive, Chester, MD 21619								
31. Date filed (Month, Day, Year) DEC 15 1998				32. Registrar's Signature <i>Beverly B. Sparks</i>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41350

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Ressie E. Paige</b>						2. Date of Death Month Day Year <b>December 25, 1998</b>			3. Time of Death <b>6:45 pm</b>																																																																																					
	4a. Facility Name (If not institution, give street and number) <b>Washington Adventist Hospital</b>						4b. City, Town, or Location of Death <b>Takoma Park</b>			4c. County of Death <b>Montgomery</b>																																																																																					
Funeral Director	5. Social Security Number <b>578-26-6539</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>76</b> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) <b>February 20, 1922</b>																																																																																				
	9. Birthplace (State or Foreign Country) <b>Virginia</b>																																																																																														
Usual Residence of Decedent																																																																																															
10a. State <b>MD</b>		10b. County <b>Prince George</b>		10c. City, Town or Location <b>Hyattsville</b>						10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No																																																																																					
10e. Street and Number <b>8402 26th Place</b>						10f. Zip Code <b>20783</b>			10g. Citizen of What Country? <b>United States</b>																																																																																						
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>																																																																																						
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>2</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Administrative Assistant</b>				16b. Kind of Business/Industry <b>Federal Government</b>																																																																																							
17. Father's Name (First, Middle, Last) <b>Rev. George W. Berkley</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Euphemia Coles</b>																																																																																									
19a. Informant's Name/Relationship (Type, Print) <b>John E. Paige - Husband</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8402 26th Place, Hyattsville, MD 20783</b>																																																																																									
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Cedar Grove Cemetery</b>			Date <b>1/2/99</b>		20c. Location - City or Town, State <b>Faber, VA</b>																																																																																						
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility <b>R. N. Horton Co. Morticians, Inc. 600 Kennedy Street, N.W., Wash., DC 20011</b>																																																																																									
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																																																																																															
<table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a.</td> <td><b>Carcinoma of the lung</b></td> <td rowspan="4">           Due to (or as a consequence of):             Due to (or as a consequence of):             Due to (or as a consequence of):             Due to (or as a consequence of):         </td> <td rowspan="4">           Approximate Interval Between Onset and Death   <b>2 years</b> </td> </tr> <tr><td>b.</td><td></td></tr> <tr><td>c.</td><td></td></tr> <tr><td>d.</td><td></td></tr> </table>												Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	<b>Carcinoma of the lung</b>	Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	Approximate Interval Between Onset and Death  <b>2 years</b>	b.		c.		d.																																																																										
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																																																																																															
<table border="0"> <tr> <td colspan="6">25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</td> <td colspan="6">26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)</td> </tr> <tr> <td colspan="4">27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined</td> <td colspan="2">28a. Date of Injury (Month, Day Year)</td> <td colspan="2">28b. Time of Injury <b>M</b></td> <td colspan="2">28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</td> <td colspan="2">28d. Describe how injury occurred</td> </tr> <tr> <td colspan="4"></td> <td colspan="4">28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)</td> <td colspan="4">28f. Location (Street and Number or Rural Route Number, City or Town, State)</td> </tr> <tr> <td colspan="6">29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</td> <td colspan="6"></td> </tr> <tr> <td colspan="6">29b. Signature and title of certifier  <b>Sajeev Anand M.D.</b></td> <td colspan="3">29c. License number <b>D-33482</b></td> <td colspan="3">29d. Date signed (Month, Day, Year) <b>December 26, 1998</b></td> </tr> <tr> <td colspan="12">30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Sajeev Anand, M.D. 7343 A Hanover Parkway, Greenbelt, Maryland 20770</b></td> </tr> <tr> <td colspan="6">31. Date filed (Month, Day, Year) <b>DEC 30 1998</b></td> <td colspan="6">32. Registrar's Signature </td> </tr> </table>												25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred						28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												29b. Signature and title of certifier  <b>Sajeev Anand M.D.</b>						29c. License number <b>D-33482</b>			29d. Date signed (Month, Day, Year) <b>December 26, 1998</b>			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Sajeev Anand, M.D. 7343 A Hanover Parkway, Greenbelt, Maryland 20770</b>												31. Date filed (Month, Day, Year) <b>DEC 30 1998</b>						32. Registrar's Signature 					
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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41351

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WILLIAM R. PERL, PH.D.				2. Date of Death Month Day Year December 24, 1998				3. Time of Death 9:49 AM										
	4a. Facility Name (If not institution, give street and number) 3901 Harrison Road				4b. City, Town, or Location of Death Beltsville				4c. County of Death Prince George's										
Funeral Director	5. Social Security Number 262-42-4153		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 92 Yrs.		8. Date of Birth (Month, Day, Year) Sept. 21, 1906		9. Birthplace (State or Foreign Country) Czechoslovakia										
	Usual Residence of Decedent																		
To Be Completed by Funeral Director	10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Beltsville				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										
	10e. Street and Number 3901 Harrison Road				10f. Zip Code 20705		10g. Citizen of What Country? U.S.A.												
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White											
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Psychologist			16b. Kind of Business/Industry Medical											
	17. Father's Name (First, Middle, Last) Rudolph Perl				18. Mother's Name (First, Middle, Maiden Surname) Camilla Fischer														
	19a. Informant's Name/Relationship (Type, Print) Lore Perl, Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3901 Harrison Road, Beltsville, Maryland 20705														
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Judean Memorial Gardens		20c. Location - City or Town, State Olney, Maryland														
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility STEIN HEBREW MEMORIAL FUNERAL HOME, INC. 232 CARROLL STREET, N.W., WASHINGTON, D.C. 20012														
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																		
	<table border="1"> <tr> <td>Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <i>Aspiration Pneumonia</i> Due to (or as a consequence of):</td> <td>Approximate Interval Between Onset and Death <i>3 weeks</i></td> </tr> <tr> <td rowspan="3">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>b. <i>Respiratory failure</i> Due to (or as a consequence of):</td> <td><i>1 day</i></td> </tr> <tr> <td>c. <i>Parkinson disease</i> Due to (or as a consequence of):</td> <td><i>30 yrs</i></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death)	a. <i>Aspiration Pneumonia</i> Due to (or as a consequence of):	Approximate Interval Between Onset and Death <i>3 weeks</i>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. <i>Respiratory failure</i> Due to (or as a consequence of):	<i>1 day</i>	c. <i>Parkinson disease</i> Due to (or as a consequence of):	<i>30 yrs</i>	d.
Immediate Cause (Final disease or condition resulting in death)	a. <i>Aspiration Pneumonia</i> Due to (or as a consequence of):	Approximate Interval Between Onset and Death <i>3 weeks</i>																	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. <i>Respiratory failure</i> Due to (or as a consequence of):	<i>1 day</i>																	
	c. <i>Parkinson disease</i> Due to (or as a consequence of):	<i>30 yrs</i>																	
	d.																		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Coronary artery disease</i>																			
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown																			
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																			
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																			
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27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred											
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)													
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																			
29b. Signature and title of certifier <i>Till Bergemann</i>				29c. License number <i>D00004483</i>		29d. Date signed (Month, Day, Year) <i>December 12-24 1998</i>													
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Till Bergemann, M.D., 115 Centerway Road, Greenbelt, Maryland 20770																			
31. Date filed (Month, Day, Year) DEC 30 1998		32. Registrar's Signature <i>[Signature]</i>																	

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
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The document contains several paragraphs of text, which are mostly illegible due to extreme fading and blurring. The text appears to be organized into sections, with some lines indented. There are three distinct black circular marks on the right side of the page, which may be punch holes or artifacts from the scanning process.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JACK PERLMAN

2. Date of Death

December 26, 1998

3. Time of Death

2:00 A.M.

4a. Facility Name (If not institution, give street and number)

Hebrew Home Of Greater Washington

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

119-07-4629

6. Sex

M 2 ☒ F

7. Age (In yrs. last birthday)

79

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

April 7, 1919

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

1131 University Blvd., West

10f. Zip Code

20902

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates

2/10/42

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Certified Public Account

16b. Kind of Business/Industry

Accounting

17. Father's Name (First, Middle, Last)

Isadore Joseph Perlman

18. Mother's Name (First, Middle, Maiden Surname)

Minnie Dime

19a. Informant's Name/Relationship (Type, Print)

Joyce Perlman, Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1131 University Boulevard, West

Silver Spring, Maryland 20902

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Judean Memorial Gardens

Date

12/29/1998

20c. Location - City or Town, State

Olney, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

STEIN HEBREW MEMORIAL FUNERAL HOME, INC.  
232 CARROLL STREET, N.W., WASHINGTON, DC 20012

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a.

ISCHEMIC CARDIOMYOPATHY

Due to (or as a consequence of):

b.

CORONARY ATHEROSCLEROSIS

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D18084

29d. Date signed (Month, Day, Year)

DECEMBER 26, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D.D. PATEL, M.D. 6121 MONTROSE RD, ROCKVILLE, MD 20852

31. Date filed (Month, Day, Year)

DEC 31 1998

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

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Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41353

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Lillian H. Phillips</b>				2. Date of Death Month <b>December</b> Day <b>26</b> , Year <b>1998</b>		3. Time of Death <b>11:18 PM</b>																									
	4a. Facility Name (If not institution, give street and number) <b>3330 North Leisure World Blvd. #210</b>				4b. City, Town, or Location of Death <b>Silver Spring</b>		4c. County of Death <b>Montgomery</b>																									
Funeral Director	5. Social Security Number <b>212-03-6887</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>83</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>July 22, 1915</b>																									
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10e. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Silver Spring</b>																									
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10f. Zip Code <b>20906</b>		10g. Citizen of What Country? <b>United States</b>																										
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>																										
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Clerk</b>		16b. Kind of Business/Industry <b>Bank</b>																												
17. Father's Name (First, Middle, Last) <b>Ludwell Lee</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Goldie Caton</b>																												
19a. Informant's Name/Relationship (Type, Print) <b>Chester C. Phillips/Husband</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3330 N. Leisure World Blvd. #210, Silver Spring, MD 20906</b>																												
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mt. Zion Cemetery</b>		Date <b>Dec. 30, 1998</b>		20c. Location - City or Town, State <b>Bethesda, Maryland</b>																										
21. Signature of Funeral Service Licensee  <b>M00198</b>				22. Name and Address of Facility <b>Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805</b>																												
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																																
<table border="1"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last         </td> <td>a.</td> <td><b>Ischemic Cardiomyopathy</b></td> <td>Years</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>b.</td> <td><b>Coronary Atherosclerosis</b></td> <td>Years</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td colspan="2">c.</td> <td></td> <td></td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td></td> <td></td> </tr> <tr> <td colspan="2">d.</td> <td></td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a.	<b>Ischemic Cardiomyopathy</b>	Years	Due to (or as a consequence of):			b.	<b>Coronary Atherosclerosis</b>	Years	Due to (or as a consequence of):			c.				Due to (or as a consequence of):				d.			
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a.	<b>Ischemic Cardiomyopathy</b>	Years																													
	Due to (or as a consequence of):																															
	b.	<b>Coronary Atherosclerosis</b>	Years																													
	Due to (or as a consequence of):																															
c.																																
Due to (or as a consequence of):																																
d.																																
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown																										
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																										
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No																										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																														
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																										
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)																										
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																																
29b. Signature and title of certifier 				29c. License number <b>D05568</b>		29d. Date signed (Month, Day, Year) <b>December 28, 1998</b>																										
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Samuel B. Itscoitz, M.D. 10313 Georgia Avenue, Silver Spring, Maryland 20902</b>																																
31. Date filed (Month, Day, Year) <b>DEC 30 1998</b>				32. Registrar's Signature 																												

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural" or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



~~Richard~~  
VOID  
CERTIFICATE #

98-41354

SEE  
CERTIFICATE #

1998 Cert. # on a 1999 Death



RICHARD PETERS

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41354

ITEMS: #23 PART 1, 27, 28A-F PER MEO G767 1-27-99 WR

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Richard L. Peters</b>				2. Date of Death Month Day Year <b>JAN. 2, 1999</b>		3. Time of Death <b>0938 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>1625 DARLEY AVENUE</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death		
Funeral Director	5. Social Security Number <b>214 76 0651</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>46</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Jan. 7, 1952</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent								
10a. State <b>Md.</b>		10b. County <b>Carroll</b>		10c. City, Town or Location <b>Westminster</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>3637 Turkeyfoot Road</b>				10f. Zip Code <b>21158</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>None</b>			16b. Kind of Business/Industry <b>N/A</b>		
17. Father's Name (First, Middle, Last) <b>Tillman Mitchell Peters</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Jean Charlotte Baker</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Jean C. Baker (Mother)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3637 Turkeyfoot Rd. Westminster, Md. 21158</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Crestlawn Mem. Gardens</b>		Date <b>1/4/99</b>		20c. Location - City or Town, State <b>Mariottsville, Md.</b>			
21. Signature of Funeral Service Licensee <b>Harry W. Haight</b>				22. Name and Address of Facility <b>Sykesville, Md. 211784 Haight Funeral Home &amp; Chapel P.O. Box 1915</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or organ failure. List only one disease on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. FOCAL BRONCHOPNEUMONIA COMPLICATING DIPHENHYDRAMINE INTOXICATION</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last									Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>Found: 1-2-99</b>		28b. Time of Injury Found <b>9:00</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>UNKNOWN</b>	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>FOUND: RESIDENCE</b>				28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>1625 DARLEY AVENUE BALTIMORE MD</b>					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier <b>Harmon McNeil</b>				29c. License number <b>O.C.M.E</b>		29d. Date signed (Month, Day, Year) <b>JAN. 3, 1999</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Natlyon P. Kossu 111 Penn Street, Baltimore, Maryland 21201</b>									
31. Date filed (Month, Day, Year) <b>JAN 08 1999</b>		32. Registrar's Signature <b>B. Sparks</b>							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be associated within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41355

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

VIOLA PATTON

2. Date of Death

Month  
12Day  
28Year  
98

3. Time of Death

6 PM

4a. Facility Name (If not institution, give street and number)

MARINER'S NURSING FACILITY

4b. City, Town, or Location of Death

CATONSVILLE

4c. County of Death

BALTIMORE

Funeral  
Director

5. Social Security Number

213-14-7230

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

86 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

(Month, Day, Year)

01-11-12

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

1363 SPELMAN RD

10f. Zip Code

21225

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOUSEWORK - DOMESTIC

16b. Kind of Business/Industry

HOUSEWORK

17. Father's Name (First, Middle, Last)

JOSEPH SLATER WILSON

18. Mother's Name (First, Middle, Maiden Surname)

NELLIE VIOLA SAMPSON

19a. Informant's Name/Relationship (Type, Print)

MRS. MARY ELA GRAVES - SISTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1363 SPELMAN RD. BALTIMORE, MD 21225

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

NCCOL

Date

1-2-99

20c. Location - City or Town, State

WORTON, MO

21. Signature of Funeral Service Licensee

Joseph O. Waller

22. Name and Address of Facility

WALLER FUNERAL HOME CHESTERTOWN, MD 21620

23. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Acute Myocardial Infarction

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive heart failure

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☒ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

☐ Medical Examiner

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

M. Delaney MD

29c. License number

D-40521

29d. Date signed (Month, Day, Year)

December 29, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR OCHANE

7845 Oakwood Road Suite 205 Glen Burnie, MD 21061

State  
Registrar

31. Date filed (Month, Day, Year)

DEC 30 1998

32. Registrar's Signature

B. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Handwritten text at the bottom of the page, possibly a signature or date, appearing to read "1900" or similar.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41356

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>HORATIO R. PROCTOR</b>				2. Date of Death Month <b>12</b> Day <b>11</b> Year <b>98</b>			3. Time of Death <b>3:50 PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>University of Maryland</b>				4b. City, Town, or Location of Death <b>Baltimore</b>			4c. County of Death <b>Baltimore</b>		
Funeral Director	5. Social Security Number <b>217-14-3017</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>79</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>3/16/19</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent				10c. City, Town or Location		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10a. State <b>Maryland</b>		10b. County <b>Queen Anne's</b>		10c. City, Town or Location <b>Chestertown</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
10e. Street and Number <b>104 Mimosa Lane</b>				10f. Zip Code <b>21620</b>		10g. Citizen of What Country? <b>USA</b>				
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>1</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Grant Officer</b>			16b. Kind of Business/Industry <b>Education</b>			
17. Father's Name (First, Middle, Last) <b>Horatio R. Proctor, Sr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Dryden Worthington</b>						
19a. Informant's Name/Relationship (Type, Print) <b>James R. Proctor/Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>104 Mimosa Lane, Chestertown, MD 21620</b>						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>St. Pauls Cemetery</b>		Date <b>12/17/98</b>		20c. Location - City or Town, State <b>Chestertown, MD</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Fellows, Helfenbein &amp; Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, MD 21620</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>Hypotension</b> Due to (or as a consequence of):  b. <b>SEPSIS</b> Due to (or as a consequence of):  c. <b>Pneumonia</b> Due to (or as a consequence of):  d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last						Approximate Interval Between Onset and Death  <b>8 hours</b>  <b>24 hours</b>  <b>36 hours</b>				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		5. Pending investigation <input type="checkbox"/> Could not be determined <input type="checkbox"/>		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
				28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier 		29c. License number <b>P12365</b>		29d. Date signed (Month, Day, Year) <b>12/11/98</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>NANCY ARIA, M.D.</b>										
31. Date filed (Month, Day, Year) <b>DEC 15 1998</b>		32. Registrar's Signature 								

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

Handwritten text at the bottom of the page, possibly a signature or date.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 41357

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>HENRY POWERS</b>				2. Date of Death Month Day Year <b>DECEMBER 26, 1998</b>		3. Time of Death <b>9:15pm</b>	
	4a. Facility Name (If not Institution, give street and number) <b>WM. HILL MANOR</b>				4b. City, Town, or Location of Death <b>EASTON</b>		4c. County of Death <b>TALBOT</b>	
Funeral Director	5. Social Security Number <b>145-30-7270</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>83</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>OCT. 20, 1915</b>	
	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>		10a. State <b>MARYLAND</b>		10b. County <b>TALBOT</b>		10c. City, Town or Location <b>EASTON</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>501 DUTCHMAN'S LANE, APT. 120</b>		10f. Zip Code <b>21601</b>		10g. Citizen of What Country? <b>U.S.</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>7</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>CLERGYMAN</b>		16b. Kind of Business/Industry <b>RELIGION</b>			
	17. Father's Name (First, Middle, Last) <b>HUGH W. S. POWERS</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>ELIZA LONGNECKER</b>			
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>WILLIAM H. POWERS/SON</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>911 BERMUDA DRIVE NESHANIC STATION, N.J 08853</b>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>CHES. CREMATION CTR.</b>		20c. Location - City or Town, State <b>1-9-99 CHESTER, MD.</b>		21. Signature of Funeral Service Licensee <i>M. E. Newman III CFSP</i>	
To Be Completed by Physician/Medical Examiner	22. Name and Address of Facility <b>FELLOWS, HELFENBEIN AND NEWMAN FUNERAL HOME 200 S. HARRISON ST. EASTON, MD. 21601</b>				23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Respiratory Failure</b> <b>COPD</b>			
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined			
To Be Completed by Physician/Medical Examiner	28a. Date of injury (Month, Day, Year)				28b. Time of injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred				28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			
To Be Completed by Physician/Medical Examiner	28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			
	29b. Signature and title of certifier <i>Wm Howard J MD</i>				29c. License number <b>D08715</b>		29d. Date signed (Month, Day, Year) <b>12/28/98</b>	
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>WILLIAM H. WOOD, JR., M.D. 506 IDLEWILD AVE. EASTON, MD. 21601</b>				31. Date filed (Month, Day, Year) <b>DEC 31 1998</b>			
	32. Registrar's Signature <i>B. Sparks</i>							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-d show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit certificate.





Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

88-41358

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Catherine Hannah Palmer</b>				2. Date of Death Month Day Year <b>Dec 23 1998</b>		3. Time of Death <b>3:30PM</b>	
	4a. Facility Name (If not Institution, give street and number) <b>Genesis ElderCare - The Pines</b>				4b. City, Town, or Location of Death <b>Easton</b>		4c. County of Death <b>Talbot</b>	
Funeral Director	5. Social Security Number <b>202-01-4587</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (in yrs. last birthday) <b>89</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>MAY 5, 1909</b>	9. Birthplace (State or Foreign Country) <b>Md.</b>
	Usual Residence of Decedent							
10a. State <b>Md.</b>		10b. County <b>Talbot</b>		10c. City, Town or Location <b>McDaniel</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>9728 Tilghman Island Rd.</b>				10f. Zip Code <b>21647</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>08</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Laborer</b>			16b. Kind of Business/Industry <b>Factory</b>	
17. Father's Name (First, Middle, Last) <b>Albert Turner</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Maggie Webb</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Leonard Palmer/ Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9714 Tilghman Island Rd. McDaniel, Md. 21647</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Claibourne Cemetery 12/30/98 Claibourne, Md.</b>			20c. Location - City or Town, State	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Dashiell Funeral Services 319 E. Dover st. Easton, Md. 21601</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>GENERALIZED SEPSIS</b> Due to (or as a consequence of): <b>SEVERE RHEUMATOID ARTHRITIS</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>1 WEEK YEARS</b>								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>COCYGEAL DECUBITUS</b> <b>LEFT HIP FRACTURE</b> <b>HYPERTENSION</b>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
				28d. Describe how Injury occurred			28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 				29c. License number <b>D26350</b>		29d. Date signed (Month, Day, Year) <b>12/24/98</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>WILLIAM S. BREMER MD 800 S. TALBOT ST ST. MICHAELS MD 21663</b>								
31. Date filed (Month, Day, Year) <b>DEC 28 1998</b>				32. Registrar's Signature 				

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41359

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) VIRGINIA M. QUINN				2. Date of Death Month Day Year DECEMBER 20, 1998				3. Time of Death 9:00AM		
	4a. Facility Name (If not institution, give street and number) HOLY CROSS REHABILITATION AND NURSING CENTER BURTONSVILLE				4b. City, Town, or Location of Death MONTGOMERY				4c. County of Death		
Funeral Director	5. Social Security Number 577-09-8323		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 87 Yrs.		8. Date of Birth (Month, Day, Year) APRIL 28, 1911		9. Birthplace (State or Foreign Country) VIRGINIA		
	Usual Residence of Decedent										
10a. State MARYLAND		10b. County PRINCE GEORGES		10c. City, Town or Location ADELPHI				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
10e. Street and Number 9400 HUGHES COURT				10f. Zip Code 20783				10g. Citizen of What Country? UNITED STATES			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) WAITRESS				16b. Kind of Business/Industry RESTAURANT			
17. Father's Name (First, Middle, Last) (UNKNOWN) THORPE					18. Mother's Name (First, Middle, Maiden Surname) VIRGIS (UNKNOWN)						
19a. Informant's Name/Relationship (Type, Print) ALDA POUNDS/ DAUGHTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9401 HUGHES COURT ADELPHI, MD 20783							
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) FT. LINCOLN CEMETERY			20c. Location - City or Town, State 12/23/98 BRENTWOOD, MD					
21. Signature of Funeral Service Licensee Anthony S. Pinsky				22. Name and Address of Facility HINES-RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVENUE SILVER SPRING, MD 20904							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CEREBROVASCULAR ACCIDENT Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):										Approximate Interval Between Onset and Death 2 WEEKS	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier Myron L. Lenkin				29c. License number D06674		29d. Date signed (Month, Day, Year) DECEMBER 21, 1998	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MYRON L. LENKIN 2309 SHOREFIELD ROAD WHEATON, MD 20902											
31. Date filed (Month, Day, Year) DEC 29 1998				32. Registrar's Signature Geneva B. Sparks							

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



amend item 5 per court order 978 9-1-16 vt  
Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item#10b,10c,10d,10e perInfG768 2/9/99 EW

Certificate of Death

Reg. No.

38 41360

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Pearl M. Raskin

2. Date of Death

Month Day Year  
Dec. 28, 1998

3. Time of Death

6:57 AM

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

578-48-4959

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Sept 24 1914

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

FL

10b. County

Palm Beach

10c. City, Town or Location

Lakeworth

Palm Springs

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

300 Village Green Circle

10f. Zip Code

33461

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married

3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

NIH Grant Specialist

16b. Kind of Business/Industry

US Government

17. Father's Name (First, Middle, Last)

Samuel Markowitz

18. Mother's Name (First, Middle, Maiden Surname)

Kraina Kanofsky

19a. Informant's Name/Relationship (Type, Print)

Leonard Raskin/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2508 Spencer Rd. Silver Spring, MD 20910

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Judean Mem. Gardens

Date

12/29/98

20c. Location - City or Town, State

Olney, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Ives-Pearson Funeral Home

2847 Wilson Blvd. Arlington, VA 22201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sepsis

Approximate interval Between Onset and Death

Days

e.

Due to (or as a consequence of):

Lung Cancer

Years

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural

2 ☐ Accident

3 ☐ Suicide

4 ☐ Homicide

5 ☐ Pending investigation

6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

D. Scott Cohen MD

29c. License number

D42051 (MD)

29d. Date signed (Month, Day, Year)

12/28/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5454 Wisconsin Ave # 1125 Chevy Chase MD 20815

31. Date filed (Month, Day, Year)

DEC 30 1998

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

T1890  
CW/14/34/84



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

08 41361

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Margaret I. Riley				2. Date of Death Month Day Year December 23, 1998				3. Time of Death 5:15 PM							
	4a. Facility Name (If not institution, give street and number) Shady Grove Adventist Nursing Center				4b. City, Town, or Location of Death Rockville				4c. County of Death Montgomery							
Funeral Director	5. Social Security Number 217-32-2035		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 62 Yrs.		8. Date of Birth (Month, Day, Year) Dec. 18, 1936		9. Birthplace (State or Foreign Country) Maryland							
	Usual Residence of Decedent															
10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Rockville				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No								
10e. Street and Number 905 Lewis Avenue				10f. Zip Code 20851				10g. Citizen of What Country? United States								
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White								
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4or 5+) 11				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cafeteria Manager				16b. Kind of Business/Industry Montgomery County Public Schools								
17. Father's Name (First, Middle, Last) Jacob E. Harmon				18. Mother's Name (First, Middle, Maiden Surname) Viola Mills												
19a. Informant's Name/Relationship (Type, Print) William C. Riley, Jr./Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 905 Lewis Avenue, Rockville, Maryland 20851												
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Parklawn Memorial Park		Date Dec. 29, 1998		20c. Location - City or Town, State Rockville, Maryland								
21. Signature of Funeral Service Licensee <i>Robert A. Humphrey</i> M00198				22. Name and Address of Facility Robert A. Humphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805												
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																
<table border="0"> <tr> <td>Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <i>Acute Renal Failure</i> Due to (or as a consequence of):</td> <td rowspan="4">Approximate Interval Between Onset and Death <i>Three days</i></td> </tr> <tr> <td rowspan="3">Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>b. <i>Sepsis</i> Due to (or as a consequence of):</td> </tr> <tr> <td>c. <i>Gangrenous Right Foot</i> Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death)	a. <i>Acute Renal Failure</i> Due to (or as a consequence of):	Approximate Interval Between Onset and Death <i>Three days</i>	Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. <i>Sepsis</i> Due to (or as a consequence of):	c. <i>Gangrenous Right Foot</i> Due to (or as a consequence of):	d.
Immediate Cause (Final disease or condition resulting in death)	a. <i>Acute Renal Failure</i> Due to (or as a consequence of):	Approximate Interval Between Onset and Death <i>Three days</i>														
Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. <i>Sepsis</i> Due to (or as a consequence of):															
	c. <i>Gangrenous Right Foot</i> Due to (or as a consequence of):															
	d.															
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Diabetes</i> <i>Peripheral Vascular Disease</i> <i>Ischemic Heart Disease</i>								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No												
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)												
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
				28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>Christy Lynn M.D.</i>				29c. License number 031839								
				29d. Date signed (Month, Day, Year) December 28, 1998												
30. Name and address of person who completed cause of death (item 23a) (Type, Print) <i>Christopher C. Oatford, MD Rockville, MD 20850</i>																
31. Date filed (Month, Day, Year) DEC 30 1998				32. Registrar's Signature <i>James B. Sparks</i>												

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Lorraine Lincoln Rumsey</b>						2. Date of Death Month <b>December</b> Day <b>27</b> , Year <b>1998</b>		3. Time of Death <b>7:30 AM</b>												
	4a. Facility Name (If not Institution, give street and number) <b>9105 Crosby Road</b>						4b. City, Town, or Location of Death <b>Silver Spring</b>		4c. County of Death <b>Montgomery</b>												
Funeral Director	5. Social Security Number <b>216-46-7329</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>85</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Sept. 9, 1913</b>		9. Birthplace (State or Foreign Country) <b>Washington, DC</b>												
	Usual Residence of Decedent																				
10a. State <b>MD</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Silver Spring</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No													
10e. Street and Number <b>9105 Crosby Road</b>				10f. Zip Code <b>20910</b>		10g. Citizen of What Country? <b>USA</b>															
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>													
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>															
17. Father's Name (First, Middle, Last) <b>Harold Sweet Lincoln</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Florence Baker</b>															
19a. Informant's Name/Relationship (Type, Print) <b>Caroline Ann Olmstead (daughter)</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>12569 Cavalier Drive, Woodbridge, VA 22192</b>															
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>St. John's Episcopal Church</b>		Date <b>12/31/98</b>		20c. Location - City or Town, State <b>Kingsville, MD</b>													
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility <b>Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901</b>															
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																					
<table border="0"> <tr> <td>Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <b>ACUTE MYOCARDIAL INFARCTION</b></td> <td>Approximate Interval Between Onset and Death <b>12 HOURS</b></td> </tr> <tr> <td rowspan="4">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>b. Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>c. Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d. Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td></td> <td></td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death)	a. <b>ACUTE MYOCARDIAL INFARCTION</b>	Approximate Interval Between Onset and Death <b>12 HOURS</b>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):		c. Due to (or as a consequence of):		d. Due to (or as a consequence of):			
Immediate Cause (Final disease or condition resulting in death)	a. <b>ACUTE MYOCARDIAL INFARCTION</b>	Approximate Interval Between Onset and Death <b>12 HOURS</b>																			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):																				
	c. Due to (or as a consequence of):																				
	d. Due to (or as a consequence of):																				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CEREBRAL INFARCT WITH MULTI-INFARCT</b> <b>DEMENTIA</b>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown													
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No													
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No													
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)		28b. Time of injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred													
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)															
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 				29c. License number <b>D08944</b>		29d. Date signed (Month, Day, Year) <b>12/27/98</b>													
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MARTIN C. SHARKEY, M.D.</b> <b>3720 FALLACUT AVE. KEESINGTON, MD - 20895</b>																					
31. Date filed (Month, Day, Year) <b>DEC 28 1998</b>		32. Registrar's Signature 																			

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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1

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Charlotte Lorraine Reihl

2. Date of Death

Month

Day

Year

December 21 1998

3. Time of Death

1655

4a. Facility Name (If not institution, give street and number)

Kent &amp; Queen Anne's Hospital

4b. City, Town, or Location of Death

Chestertown

4c. County of Death

Kent

Funeral  
Director

5. Social Security Number

215-74-6923

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

56

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

October 26, 1942

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Kent

10c. City, Town or Location

Rock Hall

10d. Inside City Limits

1 ☐ Yes 2 ☐ No

10e. Street and Number

20791 Rock Hall Avenue

10f. Zip Code

21661

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

1

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Never Worked

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

Brady Reihl

18. Mother's Name (First, Middle, Maiden Surname)

Charlotte L. Anders

19a. Informant's Name/Relationship (Type, Print)

Betty Jane McDaniel/Aunt

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20791 Rock Hall Avenue, Rock Hall, MD 21661

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Wesley Chapel Cemetery

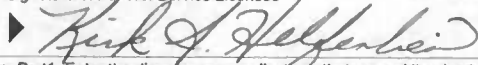
Date

12/24/98

20c. Location - City or Town, State

Rock Hall, Maryland

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

 Fellows, Helfenbein & Newnam Funeral Home, P.A.  
 130 Speer Road, Chestertown, MD 21620

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

CVA with Intracranial Hemorrhage

Approximate Interval Between Onset and Death

4 days

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

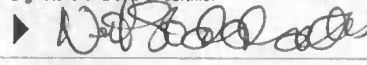
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier



29c. License number

D58996

29d. Date signed (Month, Day, Year)

12/22/98

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Neil Stoddard, 100 Brown Street, Chestertown, MD 21620

State  
Registrar

31. Date filed (Month, Day, Year)

DEC 23 1998

32. Registrar's Signature



Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

08 41364

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>LUCY K. RETALLACK</b>				2. Date of Death Month <b>12</b> Day <b>26</b> Year <b>98</b>				3. Time of Death <b>12:40p.m.</b>	
	4a. Facility Name (If not institution, give street and number) <b>Caroline Nursing Home</b>				4b. City, Town, or Location of Death <b>Denton, Maryland</b>				4c. County of Death <b>Caroline</b>	
Funeral Director	5. Social Security Number <b>213-22-9913</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>89</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>March 17, 1909</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	10a. State <b>Maryland</b>				10b. County <b>Talbot</b>		10c. City, Town or Location <b>Oxford</b>			
To Be Completed by Funeral Director	10e. Street and Number <b>27979 Otwell Road</b>				10f. Zip Code <b>21654</b>		10g. Citizen of What Country? <b>United States</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>			18b. Kind of Business/Industry <b>Own Home</b>		
	17. Father's Name (First, Middle, Last) <b>James McWilliams</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Amanda Gertrude Seymoul</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Iris R. Willis/Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6141 Old Trappe Road, Trappe, Maryland 21673</b>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Old Spring Hill Cemetery/</b>		20c. Date <b>December 30, 1998</b>		20d. Location - City or Town, State <b>Easton, Maryland</b>			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Fellows, Helfenbein &amp; Newnam Funeral Home, P.A. 200 S. Harrison Street, Easton, Maryland 21601</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Alzheimer's dementia</b> Due to (or as a consequence of):				Approximate Interval Between Onset and Death <b>years</b>					
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
			28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>047534</b>		29d. Date signed (Month, Day, Year) <b>12/28/98</b>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Wafik I. Zaki, MD, 920 Market Street, Denton, Maryland 21629</b>									
State Registrar	31. Date filed (Month, Day, Year) <b>DEC 29 1998</b>		32. Registrar's Signature 							





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last)

James Orem Rhodes

2. Date of Death  
Month Day Year

December 12, 1998

3. Time of Death

8:20am

4a. Facility Name (If not institution, give street and number)

University of Maryland Medical Systems

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

212-16-1204

6. Sex  
1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

86 Yrs.

If Under 1 Year  
Months Days

If Under 24 Hrs.  
Hours Min.

8. Date of Birth  
(Month, Day, Year)

Sept. 27, 1912 Maryland

9. Birthplace (State or Foreign Country)

Usual Residence of Decedent

10a. State

Md.

10b. County

Queen Anne's

10c. City, Town or Location

Centreville

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

104 Tilghman Avenue

10f. Zip Code

21617

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.  
Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Fork lift operator

16b. Kind of Business/Industry

Food Industry

17. Father's Name (First, Middle, Last)

James B. Rhodes

18. Mother's Name (First, Middle, Maiden Surname)

Mary L. Johnson

19a. Informant's Name/Relationship (Type, Print)

Ray D. Rhodes Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4301 Ocean Gateway; Trappe, Md. 21673

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Glen Haven Cemetery

Date

Dec. 16, 1998

20c. Location - City or Town, State

Glen Burnie, Md.

21. Signature of Funeral Service Licensee

Thomas K. Helfenbein

22. Name and Address of Facility

Fellows, Helfenbein & Newnam Funeral Home  
408 S. Liberty St., Centreville, Md. 21617

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.

Immediate Cause (Final  
disease or condition  
resulting in death)

a. Anterior Myocardial infarct

Approximate  
Interval Between  
Onset and Death

unknown

Due to (or as a consequence of):

b. Hypotension

unknown

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cardiogenic Shock

Prostate Cancer

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy  
performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings  
available prior to  
completion of cause  
of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical  
examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural  
2 ☐ Accident  
3 ☐ Suicide  
4 ☐ Homicide

5 ☐ Pending  
investigation  
6 ☐ Could not be  
determined

28a. Date of Injury  
(Month, Day, Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)

29a. Certifier  
(Check only  
one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier

Nancy

29c. License number

P12365

29d. Date signed (Month, Day, Year)

December 12, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Nancy N. Aria MD 22 South Greene Street Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

DEC 16 1998

32. Registrar's Signature

Benita G. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41366

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Luther Marshall Rafter

2. Date of Death

Month Day Year  
Dec. 19, 1998

3. Time of Death

2:15 PM

4a. Facility Name (If not institution, give street and number)

Corsica Hills - Genesis Eldercare

4b. City, Town, or Location of Death

Centreville

4c. County of Death

Queen Anne's

5. Social Security Number

220-09-7399

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

78

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
July 3, 1920

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Queen Anne's

10c. City, Town or Location

Centreville

10d. Inside City Limits

1 ☐ Yes 2 ☐ No

10e. Street and Number

205 Armstrong Avenue

10f. Zip Code

21617

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Construction

16b. Kind of Business/Industry

Self

17. Father's Name (First, Middle, Last)

Marshall J. Rafter

18. Mother's Name (First, Middle, Maiden Surname)

Emma Lewis

19a. Informant's Name/Relationship (Type, Print)

Roy W. Rafter - Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1706 Bayside Drive, Chester, MD 21619

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Chesapeake Cremation Ctr. LLC.

Date

Dec. 23, 1998

20c. Location - City or Town, State

Stevensville, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Fellows, Helfenbein &amp; Newnam Funeral Home PA

106 Shamrock Road, Chester, MD 21619

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory Failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Chronic Obstructive Pulmonary Disease

Due to (or as a consequence of):

c. NO ORAL INTAKE

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dehydration, 16-day Hypertension, 16-dayOP - Cerebrovascular Accident with Right HemiparesisAnd Aphasia, 16-day, 16-day of Right A. K. Angiogram

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

None

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier

29c. License number

823889

29d. Date signed (Month, Day, Year)

12/21/98

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

John C. Armstrong Jr. M.D., 948 Washington Ave, Chestertown MD 20620

31. Date filed (Month, Day, Year)

DEC 23 1998

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 4 1367

Amend #1, 12/28/98, BMW, Montg. Co.

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>S. Joseph SCHNEIDER</b>				2. Date of Death Month Day Year <b>Dec. 21, 1998</b>		3. Time of Death <b>12:20AM</b>																		
	4a. Facility Name (If not institution, give street and number) <b>Suburban Hospital</b>				4b. City, Town, or Location of Death <b>Bethesda</b>		4c. County of Death <b>Montgomery</b>																		
Funeral Director	5. Social Security Number <b>057-18-0454</b>		6. Sex <b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>77</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min	8. Date of Birth (Month, Day, Year) <b>Aug. 15, 1921</b>																		
	9. Birthplace (State or Foreign Country) <b>New York</b>																								
Usual Residence of Decedent																									
10a. State <b>Md.</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Bethesda</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																		
10e. Street and Number <b>8014 Aberdeen Rd.</b>				10f. Zip Code <b>20814</b>		10g. Citizen of What Country? <b>US</b>																			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WWII</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>																		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5+</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Systems Analyst</b>		16b. Kind of Business/Industry <b>IBM</b>																			
17. Father's Name (First, Middle, Last) <b>Edward Schneider</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Dora Macy</b>																					
19a. Informant's Name/Relationship (Type, Print) <b>Ruth Schneider/ Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8014 Aberdeen Rd. Bethesda, Md. 20814</b>																					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mt. Comfort Crematory 12/23/98</b>			20c. Location - City or Town, State <b>Alexandria, VA.</b>																			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Edward Sagel Funeral Direction 1091 Rockville Pike Rockville, Md. 20852</b>																					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																									
<table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a.</td> <td><b>RESPIRATORY FAILURE</b></td> <td>Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>b.</td> <td><b>PNEUMONIA</b></td> <td>Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>c.</td> <td><b>BRONCHOGENIC CARCINOMA</b></td> <td>Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d.</td> <td></td> <td>Due to (or as a consequence of):</td> <td></td> </tr> </table>									Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	<b>RESPIRATORY FAILURE</b>	Due to (or as a consequence of):		b.	<b>PNEUMONIA</b>	Due to (or as a consequence of):		c.	<b>BRONCHOGENIC CARCINOMA</b>	Due to (or as a consequence of):		d.		Due to (or as a consequence of):	
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	<b>RESPIRATORY FAILURE</b>	Due to (or as a consequence of):																						
	b.	<b>PNEUMONIA</b>	Due to (or as a consequence of):																						
	c.	<b>BRONCHOGENIC CARCINOMA</b>	Due to (or as a consequence of):																						
	d.		Due to (or as a consequence of):																						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown																			
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																			
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred																	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)																			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Other: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																									
29b. Signature and Title of Certifier  <b>MD</b>				29c. License number <b>026571</b>		29d. Date signed (Month, Day, Year) <b>12/21/98</b>																			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>IRVING MIZUS, MD 4930 DEL RAY AVE BETHESDA, MD 20814</b>																									
31. Date filed (Month, Day, Year) <b>DEC 28 1998</b>		32. Registrar's Signature 																							

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41368

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Richard James Sample				2. Date of Death Month Day Year December 22, 1998				3. Time of Death 7:54 AM	
	4a. Facility Name (If not institution, give street and number) 118 Monroe Street #702				4b. City, Town, or Location of Death Rockville				4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 217-44-0184		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (in yrs. last birthday) 80 Yrs.		8. Date of Birth (Month, Day, Year) December 15, 1918		9. Birthplace (State or Foreign Country) Indiana	
	Usual Residence of Decedent									
10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Rockville				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10e. Street and Number 118 Monroe Street, #702				10f. Zip Code 20850				10g. Citizen of What Country? United States		
11. Marital Status 1 <input type="checkbox"/> Navar Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No World War II If Yes, Give Year or Dates: War II		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) - 1				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Transportation Specialist				16b. Kind of Business/Industry Federal Government		
17. Father's Name (First, Middle, Last) Harry Paul Sample				18. Mother's Name (First, Middle, Maiden Surname) Nellie Clair Hission						
19a. Informant's Name/Relationship (Type, Print) A. Marie Sample/ Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 118 Monroe Street, #702, Rockville, MD 20850						
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Montgomery Crematorium, Inc.				20c. Location - City or Town, State Bethesda, Maryland		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Congestive Heart Failure Dua to (or as a consequence of): Old Myocardial Infarct Dua to (or as a consequence of): Coronary Arteriosclerosis Dua to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death Weeks Years		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Renal Failure Emphysema								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier 				29c. License number D02143		
29d. Date signed (Month, Day, Year) 12/22/98				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Barton J. Gershen, M.D. 15235 Shady Grove Road #100, Rockville, Maryland 20850						
31. Date filed (Month, Day, Year) DEC 28 1998				32. Registrar's Signature 						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

10+1





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41369

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Charles W. Scott</b>		2. Date of Death Month Day Year <b>Dec. 23, 1998</b>		3. Time of Death <b>6:30A.</b>
	4a. Facility Name (If not institution, give street and number) <b>13400 Rich Lynn Court</b>		4b. City, Town, or Location of Death <b>Highland</b>		4c. County of Death <b>Howard</b>
Funeral Director	5. Social Security Number <b>413-42-6695</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>68</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>April 22, 1930</b>		9. Birthplace (State or Foreign Country) <b>Tennessee</b>		
Usual Residence of Decedent					
10a. State <b>Maryland</b>		10b. County <b>Howard</b>		10c. City, Town or Location <b>Highland</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number <b>13400 Rich Lynn Court</b>		10f. Zip Code <b>20777</b>		10g. Citizen of What Country? <b>United States</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1947-1949</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Carpenter/General Contractor</b>		16b. Kind of Business/Industry <b>Self Employed</b>	
17. Father's Name (First, Middle, Last) <b>William Scott</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Rachel Myatt</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Ernestine J. Scott (wife)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>same as #10</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mt. Zion Cemetery</b>		20c. Location - City or Town, State <b>Highland, Maryland</b>	
21. Signature of Funeral Service Licensee <b>Donald V. Borgwardt</b>		22. Name and Address of Facility <b>Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>PROGRESSIVE SMALL CELL LUNG CANCER</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):					Approximate Interval Between Onset and Death <b>1 YEAR</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <b>Chitra Rajagopal</b>		29c. License number <b>MARYLAND D42452</b>		29d. Date signed (Month, Day, Year) <b>December 23, 1998</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Chitra Rajagopal, M.D. 18111 Prince Philip Dr., #327 Olney, Maryland 20832</b>					
31. Date filed (Month, Day, Year) <b>DEC 29 1998</b>		32. Registrar's Signature <b>Beverly B. Sparks</b>			

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41370

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Nancy Jane Scott				2. Date of Death Month Day Year December 28, 1998		3. Time of Death 8:00 AM	
	4a. Facility Name (If not Institution, give street and number) 4210 Round Hill Road				4b. City, Town, or Location of Death Silver Spring		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 178-30-3354		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 60 Yrs.		8. Date of Birth (Month, Day, Year) March 2, 1938	
	9. Birthplace (State or Foreign Country) Pennsylvania		10a. State Pennsylvania		10b. County Armstrong		10c. City, Town or Location Apollo	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number 1208 School Road		10f. Zip Code 15613	
	10g. Citizen of What Country? United States				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+	
	16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Registered Nurse				16b. Kind of Business/Industry Health Care			
	17. Father's Name (First, Middle, Last) Clyde Tressler				18. Mother's Name (First, Middle, Maiden Surname) Ida May Ewing			
	19a. Informant's Name/Relationship (Type, Print) Robert John Scott (husband)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as 10			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Boiling Springs Cemetery		20c. Location - City or Town, State Spring Church, Pennsylvania	
	21. Signature of Funeral Service Licensee Ellen S. Rapp				22. Name and Address of Facility Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Metastatic Non-small Cell Lung Cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):				Approximate Interval Between Onset and Death 15 months			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Son's Home				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				28d. Describe how Injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
29b. Signature and title of certifier Linda M. Burrell				29c. License number D 35996		29d. Date signed (Month, Day, Year) December 28, 1998		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Linda M. Burrell, M. D., 2101 Medical Park Drive, #210, Silver Spring, MD 20902								
31. Date filed (Month, Day, Year) DEC 29 1998				32. Registrar's Signature B. Sparks				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural," or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41371

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Edna Blanche Sigwald				2. Date of Death Month Day Year December 26, 1998		3. Time of Death 8:15 PM																																	
	4a. Facility Name (If not institution, give street and number) Greenbelt Nursing & Rehabilitation Center				4b. City, Town, or Location of Death Greenbelt		4c. County of Death Prince George's																																	
Funeral Director	5. Social Security Number 577-09-9699		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 95 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Oct. 22, 1903	9. Birthplace (State or Foreign Country) Maryland																																
	Usual Residence of Decedent																																							
To Be Completed by Funeral Director	10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Greenbelt		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No																																	
	10e. Street and Number 7010 Greenbelt Road				10f. Zip Code 20770		10g. Citizen of What Country? United States																																	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White																																	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4or 5+) 8		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home																																			
	17. Father's Name (First, Middle, Last) Charles Smith				18. Mother's Name (First, Middle, Maiden Surname) Barbara N. Bewley																																			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Laura A. Lockwood/Granddaughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3404 Andoran Court, Bowie, Maryland 20716																																			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery		Date Dec. 30, 1998		20c. Location - City or Town, State Silver Spring, Maryland																																	
	21. Signature of Funeral Service Licensee  M00198		22. Name and Address of Facility Robert A. Humphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501																																					
	23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																																							
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td colspan="6">e. Ischemic Heart Disease</td> <td rowspan="4">Approximate Interval Between Onset and Death Years</td> </tr> <tr> <td colspan="6">Due to (or as a consequence of):</td> </tr> <tr> <td rowspan="3">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td colspan="6">b. Due to (or as a consequence of):</td> </tr> <tr> <td colspan="6">c. Due to (or as a consequence of):</td> </tr> <tr> <td colspan="6">d. Due to (or as a consequence of):</td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	e. Ischemic Heart Disease						Approximate Interval Between Onset and Death Years	Due to (or as a consequence of):						Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):						c. Due to (or as a consequence of):						d. Due to (or as a consequence of):				
Immediate Cause (Final disease or condition resulting in death)	e. Ischemic Heart Disease						Approximate Interval Between Onset and Death Years																																	
	Due to (or as a consequence of):																																							
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):																																						
		c. Due to (or as a consequence of):																																						
d. Due to (or as a consequence of):																																								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown																																	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																																	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																																						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred																																
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)																																		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																																								
29b. Signature and title of certifier 				29c. License number D32261		29d. Date signed (Month, Day, Year) December 28, 1998																																		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Richard J. Feldman, M.D. 9500 Annapolis Road #A-4 Lanham, Maryland 20706																																								
31. Date filed (Month, Day, Year) DEC 30 1998		32. Registrar's Signature 																																						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41372

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Leonard P. Sileo Sr.

2. Date of Death  
Month Day Year  
December 22, 19983. Time of Death  
9:00am

4a. Facility Name (If not institution, give street and number)

SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

209-18-1081

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

70

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

June 30, 1928

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Md.

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

16640 South Westland Drive

10f. Zip Code

20877

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Auditor

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

Thomas Sileo

18. Mother's Name (First, Middle, Maiden Surname)

Angeline Ross

19a. Informant's Name/Relationship (Type, Print)

Olga Sileo (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

16640 S. Westland Dr. Gaithersburg, Md. 20877

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

Dec. 28 1998

20c. Location - City or Town, State

Silver Spring, Md.

21. Signature of Funeral Service Licensee

Curtis E. Day

22. Name and Address of Facility

DeVol Funeral Home

10 East Deer Park Dr. Gaithersburg, Md. 20877

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Ventricular Fibrillation

Approximate Interval Between Onset and Death

Minutes

Due to (or as a consequence of):

Congestive Heart Failure

Months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Ther McGinnis MD

29c. License number

D47093

29d. Date signed (Month, Day, Year)

December 22, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Martin M. McGuire, MD, 9901 Medical Center Dr., Rockville, MD 20850

31. Date filed (Month, Day, Year)

DEC 28 1998

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last) <b>Evelyn Gohagan Smith</b>				2. Date of Death Month Day Year <b>December 22, 1998</b>		3. Time of Death <b>6:30 PM</b>	
4a. Facility Name (If not institution, give street and number) <b>7516 Oskalousa Terrace</b>				4b. City, Town, or Location of Death <b>Derwood</b>		4c. County of Death <b>Montgomery</b>	
5. Social Security Number <b>146-01-3815</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>92</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>September 13, 1906</b>	
9. Birthplace (State or Foreign Country) <b>Belleville, NJ</b>		10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Derwood</b>	
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number <b>7516 Oskalousa Terrace</b>		10f. Zip Code <b>20855</b>		10g. Citizen of What Country? <b>United States</b>	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>-</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Sales Agent</b>		16b. Kind of Business/Industry <b>Real Estate</b>		17. Father's Name (First, Middle, Last) <b>Herbert P. Gohagan</b>	
18. Mother's Name (First, Middle, Maiden Surname) <b>Anna T. Manning</b>		19a. Informant's Name/Relationship (Type, Print) <b>Margaret Kerza-Kwiatecki/Daughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7609 Quintana Court, Bethesda, Maryland 20817</b>		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	
20b. Place of Disposition (Name of cemetery, crematory or other place) <b>New St. Mary's Cemetery</b>		20c. Date <b>December 28, 1998</b>		20d. Location - City or Town, State <b>Bellmawr, New Jersey</b>		21. Signature of Funeral Service Licensee 	
22. Name and Address of Facility <b>Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>a. Respiratory Failure</b> Due to (or as a consequence of): <b>Chronic Obstructive Cardiac Disease</b> <b>b. Congestive Heart Failure</b> Due to (or as a consequence of):		23b. Approximate Interval Between Onset and Death		23c. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
23d. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		23e. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		24. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>Group Home</b>		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>D53150</b>		29d. Date signed (Month, Day, Year) <b>December 23, 1998</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Shikunmala Gupta, M.D. 10810 Darnestown Road, #202, Gaithersburg, MD 20878-2675</b>		31. Date filed (Month, Day, Year) <b>DEC 28 1998</b>		32. Registrar's Signature 			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

08 41374

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Laura Lucille Dolph Spicer

2. Date of Death

Month Day Year  
December 24, 1998

3. Time of Death

1:40 pm

4a. Facility Name (If not institution, give street and number)

Randolph Hills Nursing Home

4b. City, Town, or Location of Death

Wheaton

4c. County of Death

Montgomery

5. Social Security Number

542-28-5477

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

102 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

March 7, 1896

9. Birthplace (State or Foreign Country)

Minnesota

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3912 Rickover Road

10f. Zip Code

20902

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

George O. Dolph

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Croft

19a. Informant's Name/Relationship (Type, Print)

Carolyn M. Kidwell/Granddaughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3832 Mt. Olney Lane, Olney, Maryland 20832

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

December 26, 1998  
Montgomery Crematorium, Inc.

Date

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee

MO1126

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/  
Rockville, Inc., 300 West Montgomery Avenue,  
Rockville, Maryland 20850-2805

23a. Part I. Enter the direct or indirect causes that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction

Due to (or as a consequence of):

Hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D09834

29d. Date signed (Month, Day, Year)

December 24, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Barry Rosenbaum, M.D., 3720 Farragut Avenue, Kensington, Maryland 20895

31. Date filed (Month, Day, Year)

DEC 28 1998

32. Registrar's Signature

Barry G. Sparks

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

WILLIAM NICHOLAS SQUADERE

2. Date of Death

Month DEC 27 Day 1998 Year

3. Time of Death

12:28 PM

4a. Facility Name (If not institution, give street and number)

NATIONAL NAVAL MEDICAL CENTER

4b. City, Town, or Location of Death

BETHESDA

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

087-14 5761

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

71 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
December 21, 1927

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3 Chilham Court

10f. Zip Code

20854

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No World War II

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Contracts Negotiator

16b. Kind of Business/Industry

I.B.M.

17. Father's Name (First, Middle, Last)

Nicholas Joseph Squadere

18. Mother's Name (First, Middle, Maiden Surname)

Anna Sturgeon

19a. Informant's Name/Relationship (Type, Print)

Theresa Squadere Hoehn/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

105 Fleece Flower Drive, Gaithersburg, MD 20878

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate of Heaven Cemetery

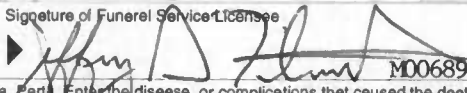
Date

December 30, 1998

20c. Location - City or Town, State

Silver Spring, Maryland

21. Signature of Funeral Service Licensee


22. Name and Address of Facility  
Robert A. Pumphrey Funeral Home/  
Rockville, Inc. 300 West Montgomery Avenue,  
Rockville, Maryland 20850-2805

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. NON SMALL CELL LUNG CARCINOMA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier



29c. License number

RES-000

29d. Date signed (Month, Day, Year)

28 DEC 98

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

BRIAN W. MECKLENBURG, LT, MC, USNR

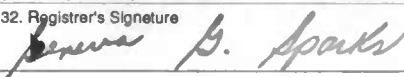
NATIONAL NAVAL MEDICAL CENTER

BETHESDA MD 20889-5600

31. Date filed (Month, Day, Year)

DEC 30 1998

32. Registrar's Signature


State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41376

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MARY JANE STANTON.

2. Date of Death

Month  
12Day  
25Year  
98

3. Time of Death

855pm

4a. Facility Name (If not institution, give street and number)

Manor Care

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

578-42-2200

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

93 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jan. 04, 1905

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

None

10b. County

None

10c. City, Town or Location

Washington, D.C.

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1761 Church Street, N.W.

10f. Zip Code

20036

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working  
life. DO NOT use retired)

Personal Assistant

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

Martin J. Stanton

18. Mother's Name (First, Middle, Maiden Surname)

Catherine Hines

19a. Informant's Name/Relationship (Type, Print)

Scott Davidson/Executor

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1761 Church Street, N.W. Wash. D.C. 20036

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Metropolitan Crematory

Date

12/27/98 Alexandria, Virginia

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee



22. Name and Address of Facility DeVol Funeral Home

2222 Wisconsin Ave., N.W. Wash. D.C. 20007

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. C.H.F.

Due to (or as a consequence of):

b. Colon Cancer

Due to (or as a consequence of):

c. Dehydration

Due to (or as a consequence of):

d. Aortic insufficiency  
e. Loss of appetiteSequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of  
injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier



29c. License number

D 20274

29d. Date signed (Month, Day, Year)

12/26/98

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

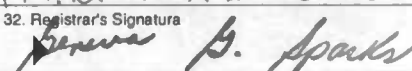
Kirti Vohra, M.D. 1299 Lambertson Drive Silver Spring Md. 20902

State  
Registrar

31. Date filed (Month, Day, Year)

DEC 29 1998

32. Registrar's Signature



Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23e show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41377

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ADA R. SUAREZ</b>				2. Date of Death Month <b>12</b> Day <b>23</b> Year <b>98</b>		3. Time of Death <b>12:06PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>LAUREL REGIONAL HOSPITAL</b>				4b. City, Town, or Location of Death <b>LAUREL</b>		4c. County of Death <b>PRINCE GEORGES</b>		
Funeral Director	5. Social Security Number <b>119-22-5721</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>71</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>MAY 16, 1927</b>	9. Birthplace (State or Foreign Country) <b>PUERTO RICO</b>	
	Usual Residence of Decedent								
10a. State <b>MD</b>		10b. County <b>MONTGOMERY</b>		10c. City, Town or Location <b>BURTONSVILLE</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>4312 REGALWOOD TERRACE</b>				10f. Zip Code <b>20866</b>		10g. Citizen of What Country? <b>USA</b>			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify: <b>PUERTO RICO</b>			14. Race - American Indian, Black, White, etc. Specify: <b>HISPANIC</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOMEMAKER</b>			16b. Kind of Business/Industry <b>DOMESTIC</b>		
17. Father's Name (First, Middle, Last) <b>ISMAEL RODRIGUEZ</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>MILAGROS CEBOLLERO</b>					
19a. Informant's Name/Relationship (Type, Print) <b>NEELKA MEIN / DAUGHTER</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4312 REGALWOOD TERRACE BURTONSVILLE MD 20866</b>					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>FORT LINCOLN CREMATORY</b>		20c. Location - City or Town, State <b>12/26/98 BRENTWOOD MARYLAND</b>			
21. Signature of Funeral Home Licensee 				22. Name and Address of Facility <b>HINES-RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVE. SILVER SPRING MD 20904</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. MYOCARDIAL INFARCTION</b> Due to (or as a consequence of): <b>b. CORONARY ARTERY DISEASE</b> Due to (or as a consequence of): <b>c. CONGESTIVE HEART FAILURE</b> Due to (or as a consequence of): <b>d.</b>								Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 		29c. License number <b>D50678</b>		29d. Date signed (Month, Day, Year) <b>12/23/98</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>RATHEV BATRA M.D. 10801 LOKWOOD DRIVE SILVER SPRING MD 20901</b>									
31. Date filed (Month, Day, Year) <b>DEC 29 1998</b>				32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41378

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Bertie B. Swann</b>				2. Date of Death Month <b>December</b> Day <b>23</b> , Year <b>1998</b>		3. Time of Death <b>4:15 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>4815 Boiling Brook Parkway</b>				4b. City, Town, or Location of Death <b>Rockville</b>		4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>578-34-3073</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>85</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Nov. 26, 1913</b>	9. Birthplace (State or Foreign Country) <b>Alabama</b>
	Usual Residence of Decedent							
10e. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Rockville</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>4815 Boiling Brook Parkway</b>				10f. Zip Code <b>20852</b>		10g. Citizen of What Country? <b>United States</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Information Specialist</b>			18b. Kind of Business/Industry <b>Federal Government</b>	
17. Father's Name (First, Middle, Last) <b>John L. Bottoms</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Maude V. Chambers</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Virginia M. Swann/Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4815 Boiling Brook Parkway, Rockville, MD 20852</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Parklawn Memorial Park</b>		20c. Location - City or Town, State <b>Rockville, Maryland</b>		
21. Signature of Funeral Service Licensee  MO1126				22. Name and Address of Facility <b>Robert A. Pumphrey Funeral Home/ Rockville, Inc., 300 West Montgomery Avenue, Rockville, Maryland 20850-2805</b>				
23e. Part I. Underlying disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Metastatic Breast Cancer</b> Due to (or as a consequence of): b. <b>Adenocarcinoma of Breast</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death <b>3 Months</b>  <b>10 Years</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 		29c. License number <b>D21531</b>		29d. Date signed (Month, Day, Year) <b>December 24, 1998</b>
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>G. Peter Pushkas, M.D. 11510 Old Georgetown Road, Rockville, Maryland 20852-2736</b>								
31. Date filed (Month, Day, Year) <b>DEC 28 1998</b>				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41379

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>NICHOLAS J. SZABADOS</b>				2. Date of Death Month Day Year <b>DEC. 23, 1998</b>		3. Time of Death <b>9:50 AM</b>	
	4e. Facility Name (If not institution, give street and number) <b>JOSEPH RICHEY HOSPICE</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>BALTIMORE</b>	
Funeral Director	5. Social Security Number <b>212-20-5749</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>86</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>OCT. 19, 1912</b>		9. Birthplace (State or Foreign Country) <b>PA.</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>MD.</b>	10b. County <b>MONTGOMERY</b>	10c. City, Town or Location <b>NORTH BETHESDA</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <b>11924 STONEWOOD LA.</b>			10f. Zip Code <b>20852</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WWII</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>5+</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>LAWYER - EDUCATOR</b>		16b. Kind of Business/Industry <b>LAW - EDUCATION</b>			
	17. Father's Name (First, Middle, Last) <b>NICHOLAS SZABADOS</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>IRMA SUSKA</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>ROSANNE D. SZABADOS/ WIFE</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>SAME AS ITEM #10</b>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>CHAMBERS CREMATORY</b>		Date <b>12-28-98</b>		20c. Location - City or Town, State <b>RIVERDALE, MD.</b>	
	21. Signature of Funeral Service Licensee <i>[Signature]</i> <b>M00091</b>				22. Name and Address of Facility <b>CHAMBERS FUNERAL HOMES, P.A., SILVER SPRING, MD. 20910</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Carcinoma of prostate</b> Due to (or as a consequence of): <b>b. Metastatic to liver</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>4 yrs</b> <b>2 yrs</b>							Approximate Interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b>				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>[Signature]</i>		29c. License number <b>D13012</b>		29d. Date signed (Month, Day, Year) <b>23 Dec 98</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>John Payne 6565 N. Charles St. Balto, Md 21204</b>								
31. Date filed (Month, Day, Year) <b>DEC 28 1998</b>		32. Registrar's Signature <i>[Signature]</i>						

1. The first part of the report deals with the general situation of the country and the progress of the work during the year.

2. The second part of the report deals with the results of the work during the year and the progress of the work during the year.

3. The third part of the report deals with the results of the work during the year and the progress of the work during the year.

4. The fourth part of the report deals with the results of the work during the year and the progress of the work during the year.

5. The fifth part of the report deals with the results of the work during the year and the progress of the work during the year.

6. The sixth part of the report deals with the results of the work during the year and the progress of the work during the year.

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41380

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Margaret Brooke Smith</b>				2. Date of Death Month Day Year <b>Dec 28, 1998</b>				3. Time of Death <b>10:24 pm</b>	
	4a. Facility Name (If not institution, give street and number) <b>New Port Assisted Living</b>				4b. City, Town, or Location of Death <b>Reisterstown</b>				4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>215-16-1494</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>91</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Jun 3, 1907</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Reisterstown</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>21 South Lake Way</b>				10f. Zip Code <b>21136</b>		10g. Citizen of What Country? <b>USA</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Administration Assistant</b>				16b. Kind of Business/Industry <b>U.S. Coast Guard</b>			
	17. Father's Name (First, Middle, Last) <b>Charles F. Brooke</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Gertrude McClelland</b>					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Jane Hilliard, daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>21 South Lake Way, Reisterstown, MD 21136</b>					
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Carroll Cremations</b>		Date <b>12/29</b>		20c. Location - City or Town, State <b>Hampstead, MD</b>			
	21. Signature of Funeral Service Licensee <b>Steven W. Eline</b>				22. Name and Address of Facility <b>Eline Funeral Home 934 South Main St., Hampstead, MD 21074</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Cerebral Thrombosis</b> Due to (or as a consequence of): <b>b. Atherosclerotic Cardiovascular Disease</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>N/A</b>		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>David [Signature]</b>				29c. License number <b>D15872</b>		29d. Date signed (Month, Day, Year) <b>December 29, 1998</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Harold Bob 25 Main St Reisterstown 21136</b>										
State Registrar	31. Date filed (Month, Day, Year) <b>DEC 29 1998</b>				32. Registrar's Signature <b>[Signature]</b>					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedant's Name (First, Middle, Last) ELSIE GRAY SHANK				2. Date of Death Month Day Year DECEMBER 29, 1998		3. Time of Death 1400	
	4a. Facility Name (If not institution, give street and number) CARROLL COUNTY GENERAL HOSPITAL				4b. City, Town, or Location of Death WESTMINSTER		4c. County of Death CARROLL	
Funeral Director	5. Social Security Number 220-36-8811	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 92 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) SEPT. 19, 1906		9. Birthplace (State or Foreign Country) MARYLAND
	Usual Residence of Decedant							
To Be Completed by Funeral Director	10a. State MARYLAND	10b. County CARROLL	10c. City, Town or Location LINWOOD			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 3981 WATSON LANE			10f. Zip Code 21764		10g. Citizen of What Country? UNITED STATES		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TEACHER			16b. Kind of Business/Industry EDUCATION		
	17. Father's Name (First, Middle, Last) JOHN PARKER GRAY				18. Mother's Name (First, Middle, Maiden Surname) EFFIE HAISLIP			
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) C. EMMITT SHANK / BROTHER-IN-LAW			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4051 KUMP STATION ROAD TANEYTOWN, MD. 21787				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) TRINITY LUTHERAN CEMETERY		Date JAN. 2 1999		20c. Location - City or Town, State TANEYTOWN, MARYLAND
	21. Signature of Funeral Service Licensee John M. Skiles			22. Name and Address of Facility SKILES FUNERAL HOME 136 E. BALTIMORE STREET TANEYTOWN, MD. 21787				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. VENTRICULAR FIBRILLATION Due to (or as a consequence of): b. CONGESTIVE HEART FAILURE Due to (or as a consequence of): c. MYOCARDIAL INFARCTION Due to (or as a consequence of): d. UREMIA							Approximate Interval Between Onset and Death MINUTES DAYS DAYS DAYS
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
Medical Certification: To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)				
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28d. Describe how injury occurred				
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
State Registrar	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and title of certifier Namman Halabi, MD			29c. License number D44 206		29d. Date signed (Month, Day, Year) 12/29/98		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NAMMAN HALABI MD CCGH 200 Memorial Avenue Westminister, Maryland 21157							
31. Date filed (Month, Day, Year) DEC 30 1998			32. Registrar's Signature B. Sparks					





Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>TIMOTHY JAMES SANN</b>		2. Date of Death Month Day Year <b>DEC. 18, 1998</b>		3. Time of Death <b>0245 AM</b>	
4a. Facility Name (If not institution, give street and number) <b>GLEBE ROAD / 400 YARDS FROM UNIONVILLE RD.</b>		4b. City, Town, or Location of Death <b>EASTON</b>		4c. County of Death <b>TALBOT</b>	
5. Social Security Number <b>215-27-9798</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>25</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>NOV. 3, 1973</b>
9. Birthplace (State or Foreign Country) <b>MARYLAND</b>		Usual Residence of Decedent			
10a. State <b>MARYLAND</b>	10b. County <b>TALBOT</b>	10c. City, Town or Location <b>ST. MICHAELS</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>701 NEW LANE</b>		10f. Zip Code <b>21663</b>		10g. Citizen of What Country? <b>U.S.</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1992-93</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>			
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>MANAGER/COOK</b>		16b. Kind of Business/Industry <b>RESTAURANT</b>			
17. Father's Name (First, Middle, Last) <b>ALEX MICHAEL SANN, SR.</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>DENISE PUTMAN</b>			
19a. Informant's Name/Relationship (Type, Print) <b>JANEL A. SANN/WIFE</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P.O. BOX 1078 ST. MICHAELS, MARYLAND 21663</b>			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>CHESAPEAKE CREM. CTR.</b>		20c. Location - City or Town, State <b>12-24-98 CHESTER, MARYLAND</b>	
21. Signature of Funeral Service Licensee <i>D. Newman</i> CFSP		22. Name and Address of Facility <b>FELLOWS, HELFENBEIN AND NEWMAN FUNERAL HOME 200 S. HARRISON ST., EASTON, MARYLAND 21601</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Multiple Injuries</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>		Approximate Interval Between Onset and Death			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>AT SCENE</b>		27. Manner of Death <input type="checkbox"/> Natural <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			
28a. Date of Injury (Month, Day Year) <b>12/18/98</b>		28b. Time of Injury <b>2:16 AM</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred <b>motor vehicle collision</b>		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>street</b>			
28f. Location (Street and Number, or Rural Route Number, City or Town, State) <b>Easton, Md Glebe Road</b>		29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			
29b. Signature and title of certifier <i>Dennis J. Chute me</i>		29c. License number <b>O.C.M.E</b>		29d. Date signed (Month, Day, Year) <b>DEC. 19, 1998</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dennis J. Chute me 111 Penn Street, Baltimore, Maryland 21201</b>					
31. Date filed (Month, Day, Year) <b>DEC 28 1998</b>		32. Registrar's Signature <i>B. Sparks</i>			





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

08 41383

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DOROTHY JOYCE TRAVERS				2. Date of Death Month Day Year DECEMBER 21, 1998		3. Time of Death 5:51AM	
	4a. Facility Name (If not institution, give street and number) 2107 BUCKNELL TERRACE				4b. City, Town, or Location of Death WHEATON,		4c. County of Death MONTGOMERY	
Funeral Director	5. Social Security Number 012-01-4690		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 90		8. Date of Birth (Month, Day, Year) AUG. 16, 1908	
	9. Birthplace (State or Foreign Country) MASSACHUSETTS		10a. State MD		10b. County MONTGOMERY		10c. City, Town or Location WHEATON	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number 2107 BUCKNELL TERRACE		10f. Zip Code 20902	
	10g. Citizen of What Country? USA				11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: WHITE		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ADMINISTRATIVE ASSISTANT				16b. Kind of Business/Industry HEALTH CARE			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) EDWARD JOYCE				18. Mother's Name (First, Middle, Maiden Surname) MARY VENO			
	19a. Informant's Name/Relationship (Type, Print) WALTER TRAVERS (SON)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2107 BUCKNELL TERRACE SILVER SPRING, MD 20902			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) FORT LINCOLN CREMATORY		20c. Location - City or Town, State 12-23-98 BRENTWOOD, MD	
	21. Signature of Funeral Service Licensee <i>David J. Th...</i>				22. Name and Address of Facility HINES-RINALDI 11800 NEW HAMPSHIRE AVENUE SILVER SPRING, MD 20904			
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CONGESTIVE HEART FAILURE Due to (or as a consequence of): b. ARTERIOCLEROTIC CIRCULATORY DISEASE Due to (or as a consequence of): c. DIABETES MELLITUS Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
To Be Completed by Physician/Medical Examiner	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>mo. (ONE)</i>		29c. License number D15236	
	29d. Date signed (Month, Day, Year) DECEMBER 22, 1998				29e. Name and address of person who completed cause of death (Item 23a) (Type, Print) CARL E. MARGOLIS, MO. 11125 ROCKVILLE PIKE, ROCKVILLE, MD 20852			
State Registrar	31. Date filed (Month, Day, Year) DEC 29 1998				32. Registrar's Signature <i>B. Sparks</i>			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41384

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Audrey Sapp Tate</b>				2. Date of Death Month Day Year <b>December 18, 1998</b>				3. Time of Death <b>3:09 PM</b>			
	4a. Facility Name (If not Institution, give street and number) <b>Washington Adventist Hospital</b>				4b. City, Town, or Location of Death <b>Takoma Park</b>				4c. County of Death <b>Montgomery</b>			
Funeral Director	5. Social Security Number <b>225-42-4309</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>76</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>June 26, 1922</b>		9. Birthplace (State or Foreign Country) <b>Virginia</b>			
	Usual Residence of Decedent				10a. State <b>Virginia</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Norfolk</b>			
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number <b>2700 Virginia Beach Boulevard</b>				10f. Zip Code <b>23504</b>			
	10g. Citizen of What Country? <b>United States</b>				11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			
	13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5+</b> College (1-4 or 5+)			
	16. Kind of Business/Industry <b>Public Schools</b>				17. Father's Name (First, Middle, Last) <b>James Lee Sapp</b>				18. Mother's Name (First, Middle, Maiden Summa) <b>Leola D. Cook</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Audrey J. Childs, niece</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1624 Webster St. N.W., Washington, D.C. 20011</b>				20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			
	20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Calvary Cemetery</b>				20c. Location - City or Town, State <b>12/29/98 Norfolk, Virginia</b>				21. Signature of Funeral Service Licensee 			
	22. Name and Address of Facility <b>McGuire Funeral Service, Inc. 7400 Georgia Ave. N.W., Washington, D.C.</b>				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>a. Respiratory failure</b> Due to (or as a consequence of): <b>b. Chronic Obstructive Lung disease</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>				Approximate Interval Between Onset and Death <b>18 days</b> <b>6 months</b>			
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Renal failure</b>				23c. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No				25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year) <b>12/29/98</b>				28b. Time of Injury <b>M</b>			
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)				
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and Title of certifier 				29c. License number <b>016273 MD</b>			
	29d. Date signed (Month, Day, Year) <b>12/18/98</b>				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>REXATHY MURTHY MD - 6130 LANDOVER RD COTTEVERLY MD</b>				31. Date filed (Month, Day, Year) <b>DEC 29 1998</b>			
	32. Registrar's Signature 				33. State Registrar <b>DEC 29 1998</b>				34. State Registrar			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

08 41385

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>RUTH H. TALIAFERRO</b>				2. Date of Death Month Day Year <b>DECEMBER 27, 1998</b>		3. Time of Death <b>7:10PM</b>	
4a. Facility Name (If not institution, give street and number) <b>15308 BASSWOOD COURT</b>				4b. City, Town, or Location of Death <b>ROCKVILLE</b>		4c. County of Death <b>MONTGOMERY</b>	
5. Social Security Number <b>579-16-6360</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>88</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>JAN. 27, 1910</b>	
9. Birthplace (State or Foreign Country) <b>MARYLAND</b>		10a. State <b>MARYLAND</b>		10b. County <b>MONTGOMERY</b>		10c. City, Town or Location <b>ROCKVILLE</b>	
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number <b>15308 BASSWOOD COURT</b>		10f. Zip Code <b>20853</b>		10g. Citizen of What Country? <b>UNITED STATES</b>	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b> College (1-4or 5+) <b>2</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>INSURANCE ADJUSTER</b>		16b. Kind of Business/Industry <b>INSURANCE</b>		17. Father's Name (First, Middle, Last) <b>JOHN HAMMOND</b>	
18. Mother's Name (First, Middle, Maiden Surname) <b>EMMA (UNKNOWN)</b>		19a. Informant's Name/Relationship (Type, Print) <b>CAROLYN BLAUVELT</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>11469 COLUMBIA PIKE APT. C2 SILVER SPRING, MD20904</b>		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	
20b. Place of Disposition (Name of cemetery, crematory or other place) <b>FT. LINCOLN CEMETERY</b>		20c. Date <b>12/31/98</b>		20d. Location - City or Town, State <b>BRENTWOOD, MD</b>		21. Signature of Funeral Service Licensee 	
22. Name and Address of Facility <b>HINES-RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVE. SILVER SPRING, MD20904</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. ATHEOSCLEROTIC CARDIOVASCULAR DISEASE</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):		Approximate Interval Between Onset and Death		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
29b. Signature and title of certifier 		29c. License number <b>D31563</b>		29d. Date signed (Month, Day, Year) <b>DECEMBER 28, 1998</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>CHARLES M. BENNER, MD 11251 LOCKWOOD DRIVE SILVER SPRING, MD 20901</b>	
31. Date filed (Month, Day, Year) <b>DEC 29 1998</b>		32. Registrar's Signature 		33. State Registrar		34. State Registrar	





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State of Maryland / Department of Health and Mental Hygiene

38 41386

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Lois G. Taylor</b>		2. Date of Death Month: <b>DEC</b> Day: <b>29</b> Year: <b>98</b>		3. Time of Death <b>220 AM</b>
	4a. Facility Name (If not institution, give street and number) <b>Howard County General Hospital</b>		4b. City, Town, or Location of Death <b>Columbia</b>		4c. County of Death <b>Howard</b>
Funeral Director	5. Social Security Number <b>577-40-4310</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>75</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>May 1, 1923</b>	9. Birthplace (State or Foreign Country) <b>Virginia</b>
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State <b>MD</b>	10b. County <b>Montgomery</b>	10c. City, Town or Location <b>Rockville</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number <b>4105 Southend Road</b>		10f. Zip Code <b>20853</b>		10g. Citizen of What Country? <b>USA</b>
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (14 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>
To Be Completed by Physician/Medical Examiner	16b. Kind of Business/Industry <b>Own Home</b>		17. Father's Name (First, Middle, Last) <b>Roy William Good</b>		
	18. Mother's Name (First, Middle, Maiden Surname) <b>Anna Mary Smucker</b>		19a. Informant's Name/Relationship (Type, Print) <b>H.L. Taylor (husband)</b>		
	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4105 Southend Road, Rockville, MD 20853</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		
	20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Timberville Church of the Brethren</b>		20c. Location - City or Town, State <b>Timberville, Virginia</b>		
Physician /Medical Examiner	21. Signature of Funeral Service Licensee <b>Mark P. Pital</b>		22. Name and Address of Facility <b>Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901</b>		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.				
	Immediate Cause (Final disease or condition resulting in death) <b>a. Myocardial Infarction</b> Due to (or as a consequence of): <b>b. Coronary Artery Disease</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>				
	Approximate Interval Between Onset and Death <b>1 Hour</b> <b>5 Years</b>				
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Respiratory Failure</b> <b>Congestive Heart Failure</b>				
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown				
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
To Be Completed by Physician/Medical Examiner	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>
	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how Injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
State Registrar	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
	29b. Signature and title of certifier <b>Sanjay P. Shah, MD</b>		29c. License number <b>DO052940</b>		29d. Date signed (Month, Day, Year) <b>DEC 29 98</b>
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>SANJAY P. SHAH, MD 10805 Hickory Ridge Rd #210, Columbia, MD 21044</b>				
	31. Date filed (Month, Day, Year) <b>DEC 31 1998</b>		32. Registrar's Signature <b>Benita B. Sparks</b>		

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



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Amend #10e, #19b, 12/31/98, BW, Monty Co.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Mathilda Terselic</b>		2. Date of Death Month <b>December</b> Day <b>23</b> Year <b>1998</b>		3. Time of Death <b>6:20 PM</b>	
4a. Facility Name (If not institution, give street and number) <b>Rockville Nursing Home</b>		4b. City, Town, or Location of Death <b>Rockville</b>		4c. County of Death <b>Montgomery</b>	
5. Social Security Number <b>288-30-6093</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>86</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Feb. 22, 1912</b>
9. Birthplace (State or Foreign Country) <b>Kenosha, WI</b>					
10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Rockville</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>18113 Hollingsworth Drive</b> <del>1843 Hollingsworth Drive</del>			
10f. Zip Code <b>20855</b>		10g. Citizen of What Country? <b>United States</b>			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>			
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Retailer/Partner</b>		16b. Kind of Business/Industry <b>Automobile Parts</b>			
17. Father's Name (First, Middle, Last) <b>Frank Slana</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Frances Suhadolc</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Richard Terselic (Son)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>18113 Hollingsworth Drive</b> <del>1843 Hollingsworth Drive</del> , <b>Rockville, MD 20855</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>St. Mary's Cemetery</b>		20c. Location - City or Town, State <b>12/29/98 Rockville, Maryland</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>DeVol Funeral Home</b> <b>10 East Deer Park Drive</b> <b>Gaithersburg, MD 20877</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Respiratory failure</b> Due to (or as a consequence of): <b>b. Cerebral Hemorrhage</b> Due to (or as a consequence of): <b>c. Hypertension</b> Due to (or as a consequence of): <b>d.</b>		Approximate Interval Between Onset and Death <b>Day</b> <b>6 month</b> <b>Years</b>			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>D21392</b>	
29d. Date signed (Month, Day, Year) <b>December 24, 1998</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Patricia D. Kellogg, M.D. 809 Veirs Mill Road, Rockville, MD 20851-1689</b>			
31. Date filed (Month, Day, Year) <b>DEC 28 1998</b>		32. Registrar's Signature 			

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 41388

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>FRANKLIN CLAY THOMPSON</b>				2. Date of Death Month Day Year <b>DEC. 22, 1998</b>		3. Time of Death <b>8:50 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Shady Grove Adventist Hospital</b>				4b. City, Town, or Location of Death <b>Rockville</b>		4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>220-74-7893</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>35</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Jan. 30, 1963</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>MD</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Gaithersburg</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number <b>8333 Shady Spring Drive</b>		10f. Zip Code <b>20877</b>	
	10g. Citizen of What Country? <b>U.S.A.</b>				11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Mail Sorter</b>				16b. Kind of Business/Industry <b>Rockville Mailing Co.</b>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>Wilbert Thompson</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Betty A. Stevenson</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Betty A. Thompson (Mother)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8333 Shady Spring Dr., Gaithersburg, MD 20877</b>			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Emory Grove Cemetery</b>			
	20c. Location - City or Town, State <b>12/28/98 Gaithersburg, MD</b>				21. Signature of Funeral Service Licensed <i>George R. Snowden</i>			
To Be Completed by Physician/Medical Examiner	22. Name and Address of Facility <b>SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850</b>				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  e. <b>Respiratory Failure</b> Dua to (or as a consequence of): minutes b. <b>AIDS</b> Dua to (or as a consequence of): Years c. Dua to (or as a consequence of): d. Dua to (or as a consequence of):			
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			
To Be Completed by Physician/Medical Examiner	28a. Date of Injury (Month, Day Year)				28b. Time of Injury <b>M</b>			
	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				28d. Describe how injury occurred			
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <i>William Dooley</i>			
To Be Completed by Physician/Medical Examiner	29c. License number <b>033261</b>				29d. Date signed (Month, Day, Year) <b>December 22, 1998</b>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. William Dooley, 9901 Medical Center Dr., Rockville, MD 20850</b>				31. Data filed (Month, Day, Year) <b>DEC 28 1998</b>			
To Be Completed by Physician/Medical Examiner	32. Registrar's Signature <i>B. Sparks</i>				33. State Registrar			
	34. State Registrar				35. State Registrar			





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) John Walter Thompson		2. Date of Death Month: December Day: 11 Year: 1998		3. Time of Death 0712
4a. Facility Name (If not institution, give street and number) The Kent and Queen Anne's Hospital, Inc.		4b. City, Town, or Location of Death Chestertown		4c. County of Death Kent
5. Social Security Number 217-03-9091	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 83 Yrs.	8. Date of Birth (Month, Day, Year) June 1, 1915	9. Birthplace (State or Foreign Country) Maryland
Usual Residence of Decedent				
10a. State Maryland	10b. County Kent	10c. City, Town or Location Chestertown		10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
10e. Street and Number 408 Morgnac Road Apt 303		10f. Zip Code 21620		10g. Citizen of What Country? USA
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): 11 College (1-4 or 5+)		
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Truck Driver		16b. Kind of Business/Industry Oil Industry		
17. Father's Name (First, Middle, Last) John Merritt Thompson		18. Mother's Name (First, Middle, Maiden Surname) Mary Caroline Haddaway		
19a. Informant's Name/Relationship (Type, Print) Katherine A. Thompson/Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 408 Morgnac Road, Apt #303, Chestertown, MD 21620		
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Chester Cemetery		20c. Location - City or Town, State 12/14/98 Chestertown, MD
21. Signature of Funeral Service Licensee <i>Frank A. Helfenbein</i>		22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, MD 21620		
23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.				
Immediate Cause (Final disease or condition resulting in death)		a. CARDIAC ARREST		Approximate Interval Between Onset and Death MINUTES
Due to (or as a consequence of):		b. HYPERTENSIVE HEART DISEASE		HOURS
Due to (or as a consequence of):		c. ACUTE RENAL FAILURE		HOURS
Due to (or as a consequence of):		d. RENAL ARTERIAL THROMBOSIS		HOURS
23b. Pert 2. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.				
23c. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
29b. Signature and title of certifier <i>Paul R. Johnson MD</i>		29c. License number D0052487		29d. Date signed (Month, Day, Year) 12/11/98
30. Name and address of person who completed cause of death (item 23e) (Type, Print) PAUL JOHNSON 100 BROWN ST CHESTERTOWN, MD 21620				
31. Date filed (Month, Day, Year) DEC 15 1998		32. Registrar's Signature <i>Benita B. Sparks</i>		

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

88 41390

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Clarence Philip Thomas, Sr.				2. Date of Death Month Day Year December 27, 1998		3. Time of Death 6:00 pm									
	4a. Facility Name (If not Institution, give street and number) 3612 Bonnie Lane				4b. City, Town, or Location of Death Linkwood		4c. County of Death Dorchester									
Funeral Director	5. Social Security Number 216-16-7988	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 77 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) May 17, 1921		9. Birthplace (State or Foreign Country) Smithville, MD								
	Usual Residence of Decedent															
To Be Completed by Funeral Director	10a. State Maryland	10b. County Dorchester	10c. City, Town or Location Linkwood			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										
	10e. Street and Number 3612 Bonnie Lane			10f. Zip Code 21835		10g. Citizen of What Country? United States										
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White									
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collage (1-4or 5+) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Bus Driver		16b. Kind of Business/Industry Public Transportation											
	17. Father's Name (First, Middle, Last) Tennessee Thomas				18. Mother's Name (First, Middle, Maiden Surname) Martha Jane Hayman											
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Clarence P. Thomas, Jr./Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14870 Oakland Road, Ridgely, Maryland 21660											
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Concord Cemetery/December 31, 1998 Federalsburg, Maryland		20c. Location - City or Town, State											
	21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 200 S. Harrison Street, Easton, MD 21601													
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.															
	<table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a. Pulmonary Edema Due to (or as a consequence of):</td> <td>hours</td> </tr> <tr> <td>b. Congestive Heart Failure Due to (or as a consequence of):</td> <td>1 year</td> </tr> <tr> <td>c. Endstage COPD/Hypertension Due to (or as a consequence of):</td> <td>years</td> </tr> <tr> <td>d.</td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Pulmonary Edema Due to (or as a consequence of):	hours	b. Congestive Heart Failure Due to (or as a consequence of):	1 year	c. Endstage COPD/Hypertension Due to (or as a consequence of):	years	d.
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Pulmonary Edema Due to (or as a consequence of):	hours														
	b. Congestive Heart Failure Due to (or as a consequence of):	1 year														
	c. Endstage COPD/Hypertension Due to (or as a consequence of):	years														
	d.															
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)														
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred												
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Lois Narr D.O.</i>		29c. License number H44615		29d. Date signed (Month, Day, Year) 12/29/98										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lois Narr, D.O., 2 Aurora St., Cambridge MD 21613																
31. Date filed (Month, Day, Year) DEC 29 1998		32. Registrar's Signature <i>[Signature]</i>														

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41391

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ANNA TOCZYLOWSKI				2. Date of Death Month Day Year DECEMBER 26, 1998		3. Time of Death 8:03am	
	4a. Facility Name (If not institution, give street and number) WILLIAM HILL HEALTH CARE				4b. City, Town, or Location of Death EASTON		4c. County of Death TALBOT	
Funeral Director	5. Social Security Number 164-03-0682		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 88 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) February 15, 1910	
	9. Birthplace (State or Foreign Country) Poland							
To Be Completed by Funeral Director	10a. State Maryland		10b. County Talbot		10c. City, Town or Location Easton			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
	10e. Street and Number 501 Dutchman's Lane				10f. Zip Code 21601		10g. Citizen of What Country? United States	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home			
	17. Father's Name (First, Middle, Last) Adam Serba				18. Mother's Name (First, Middle, Maiden Surname) Bronislawa (Maiden Surname Unknown)			
	19a. Informant's Name/Relationship (Type, Print) Joan Hassel/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 100 Gloucester Road, Queenstown, Maryland 21658			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) St. Josephs Cemetery/December 30, 1998 Chews Landing, N		20c. Location - City or Town, State			
	21. Signature of Funeral Service Licensee M.E. Newnam				22. Name and Address of Facility Fellows, Helffenbein & Newnam Funeral Home, P.A. 200 S. Harrison Street, Easton, Maryland 21601			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cerebral Artery Occlusion Due to (or as a consequence of): b. Cerebral Arteriosclerosis Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death Minutes 1045							
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ASAD with AF							
Physician /Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier William H Wood Jr MD				29c. License number D08715		29d. Date signed (Month, Day, Year) 12/28/98	
State Registrar	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) William H. Wood, Jr. MD, 506 Idlewild Avenue, Easton, Maryland 21601							
	31. Date filed (Month, Day, Year) DEC 28 1998		32. Registrar's Signature Benita B. Sparks					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Amend #18,1/7/99,BMW,Montg. Co.

98 41392

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Virginia Hawkins Waters				2. Date of Death Month Day Year December 29, 1998				3. Time of Death 2:50pm	
	4a. Facility Name (If not institution, give street and number) Montgomery Village Care & Rehab Center				4b. City, Town, or Location of Death Gaithersburg				4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 214-32-8540		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 88 Yrs.		8. Date of Birth (Month, Day, Year) Aug. 16, 1910		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent									
10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Gaithersburg				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10e. Street and Number 11 Chestnut Street #1				10f. Zip Code 20877				10g. Citizen of What Country? United States		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife				16b. Kind of Business/Industry Own home		
17. Father's Name (First, Middle, Last) Sydney Hawkins				18. Mother's Name (First, Middle, Maiden Surname) Mary Case						
19a. Informant's Name/Relationship (Type, Print) Justine Brockett-Owens (Niece)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4390 lorcom Lane #410, Arlington, VA 22207						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Parklawn Memorial Park				20c. Location - City or Town, State 1/2/99 Rockville, Maryland				
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD 20877						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. CORONARY ARTERY DISEASE Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death YEARS		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier  MD				29c. License number 30692				29d. Date signed (Month, Day, Year) DECEMBER 30, 1998		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gabriel A. Berrebi, M.D. 15200 Shady Grove Road #305; Rockville, MD 20850										
31. Date filed (Month, Day, Year) DEC 31 1998		32. Registrar's Signature 								

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41393

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

DONALD HATHAWAY WILLIAMS

2. Date of Death  
Month Day Year

DECEMBER 23, 1998

3. Time of Death

3:15 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

MONTGOMERY GENERAL HOSPITAL

4b. City, Town, or Location of Death

OLNEY

4c. County of Death

MONTGOMERY

5. Social Security Number

579-09-5504

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

81

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

FEB. 16, 1917

9. Birthplace (State or Foreign Country)

WASHINGTON, D.C.

Usual Residence of Decedent

10a. State

MD.

10b. County

MONTGOMERY

10c. City, Town or Location

SILVER SPRING

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

14646 KELMSCOT DRIVE

10f. Zip Code

20906

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No WWII  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12College (1-4 or 5+)  
416a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

DAIRY TECHNOLOGIST

16b. Kind of Business/Industry

DAIRY TRADE  
ASSOCIATION

17. Father's Name (First, Middle, Last)

CHARLES WILLIAMS

18. Mother's Name (First, Middle, Maiden Surname)

MATTIE HATHAWAY

19a. Informant's Name/Relationship (Type, Print)

CAROLYN H. WILLIAMS, WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14646 KELMSCOT DRIVE, SILVER SPRING, MD. 20906

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

METROPOLITAN CREMATORY

Date

12/26/98

20c. Location - City or Town, State

ALEXANDRIA, VIRGINIA

21. Signature of Funeral Service Licensee

Muriel H. Barber

22. Name and Address of Facility

MURIEL H. BARBER FUNERAL HOME  
P.O. BOX 5038, LAYTONSVILLE, MD. 2088223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.

BRAINSTEM STROKE

Approximate  
Interval Between  
Onset and Death

2 DAYS

Immediate Cause (Final  
disease or condition  
resulting in death)

ISCHEMIC CARDIOMYOPATHY

6 MONTHS

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

END STATE RENAL DISEASE ON DIALYSIS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

TYPE II DIABETES MELLITUS

24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

P. H. H. H.

29c. License number

D35045

29d. Date signed (Month, Day, Year)

DECEMBER 24, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. PHILIP HENJUM, 3416 OLANDWOOD COURT #204, OLNEY, MARYLAND 20832

State  
Registrar

31. Date filed (Month, Day, Year)

DEC 29 1998

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98/41394

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JEAN WAGGONER WILSON

2. Date of Death

Month Day Year  
DECEMBER 28, 1998

3. Time of Death

8:45 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

12521 Montclair Drive

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

128-26-1128

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

67 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Oct. 5, 1931

9. Birthplace (State or Foreign Country)

Kentucky

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

12521 Montclair Drive

10f. Zip Code

20904

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Registered Nurse

16b. Kind of Business/Industry

Health Care

17. Father's Name (First, Middle, Last)

William C. Waggoner

18. Mother's Name (First, Middle, Maiden Surname)

Una Safriet

19a. Informant's Name/Relationship (Type, Print)

Richard E. Wilson (husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12521 Montclair Drive, Silver Spring, MD 20904

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate of Heaven Cemetery 12/31/98 Silver Spring, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Steven S. Sotos

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc. 500 University Blvd. West  
Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Lung Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

6 weeks

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

George A. Sotos

29c. License number

D43083

29d. Date signed (Month, Day, Year)

December 29, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

George A. Sotos

9707 Medical Center Dr. #300 Rockville, MD 20850

31. Date filed (Month, Day, Year)

DEC 30 1998

32. Registrar's Signature

Denise B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

841395

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

GENEVIEVE HACKNEY WOHL

2. Date of Death

December 21, 1998

3. Time of Death

12:30 PM

4a. Facility Name (If not institution, give street and number)

Hebrew Home of Greater Washington

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

233-07-1981

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Aug. 1, 1919

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

Virginia

10b. County

Fairfax

10c. City, Town or Location

Vienna

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1830 Clifdale Court

10f. Zip Code

22182

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Homemaker

17. Father's Name (First, Middle, Last)

Ellis V. Hackney

18. Mother's Name (First, Middle, Maiden Surname)

Chloe White

19a. Informant's Name/Relationship (Type, Print)

Paul Wohl/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1830 Clifdale Ct., Vienna, Va. 22182

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Arlington National Cem.

Date

12/29/98

20c. Location - City or Town, State

Arlington, Virginia

21. Signature of Funeral Service Licensee

Peter A. Pratelli

22. Name and Address of Facility

Money & King Vienna Funeral Home  
171 W. Maple Ave., Vienna, Va23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. DYSPHAGIA

Due to (or as a consequence of):

b. PICK'S DISEASE

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

MONTHS

YEARS

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

MALNUTRITION

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29e. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Steven Lipson

29c. License number

D05885

29d. Date signed (Month, Day, Year)

12/21/98

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

STEVEN LIPSON 6121 MONTROSE RD, ROCKVILLE, MD

State  
Registrar

31. Date filed (Month, Day, Year)

DEC 31 1998

32. Registrar's Signature

Genevieve B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Walter August Wolf				2. Date of Death Month Day Year Dec 28 1998				3. Time of Death 2:10pm		
	4a. Facility Name (If not institution, give street and number) 2216 Cherokee Drive				4b. City, Town, or Location of Death Westminster				4c. County of Death Carroll		
Funeral Director	5. Social Security Number 213-08-6886		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 90 Yrs.		8. Date of Birth (Month, Day, Year) Dec 18 1908		9. Birthplace (State or Foreign Country) MD		
	Usual Residence of Decedent										
To Be Completed by Funeral Director	10a. State Md		10b. County Carroll		10c. City, Town or Location Westminster				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 2216 Cherokee Drive				10f. Zip Code 21157		10g. Citizen of What Country? USA				
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DD NDT use retired) cabinet maker				16b. Kind of Business/Industry millwork		
	17. Father's Name (First, Middle, Last) George Wolf				18. Mother's Name (First, Middle, Maiden Surname) Cora Hess						
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Mildred Allen Wolf (spouse)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2216 Cherokee Dr., Westminster, MD 21157						
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Memorial		Date 1-1-99		20c. Location - City or Town, State Eldridge, MD				
	21. Signature of Funeral Service Licensee ▶ Paige Hught Herbert				22. Name and Address of Facility Haight Funeral Home & Chapel P.O. Box 195 Sykesville, MD 21784						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Dementia Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):  Approximate Interval Between Onset and Death 8 YRS										
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier ▶ M. McEvoy M.D.				29c. License number D33681		29d. Date signed (Month, Day, Year) 12/29/98	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. McEvoy, Eldersburg, MD 21784 1380 Progress Way S-114											
31. Date filed (Month, Day, Year) DEC 30 1998		32. Registrar's Signature ▶ P. Sparks									

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 41397

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last) Owen Leroy Walbert  
2. Date of Death Month Day Year December 17, 1998  
3. Time of Death 8:20a.m.

Funeral  
Director

4a. Facility Name (If not institution, give street and number) Kent & Queen Anne's Hospital  
4b. City, Town, or Location of Death Chestertown  
4c. County of Death Kent

5. Social Security Number 214-28-3725  
6. Sex ☒ M ☐ F  
7. Age (In yrs. last birthday) 73 Yrs.  
8. Date of Birth (Month, Day, Year) Dec. 21, 1924  
9. Birthplace (State or Foreign Country) Maryland

Usual Residence of Decedent  
10a. State Maryland  
10b. County Kent  
10c. City, Town or Location Chestertown  
10d. Inside City Limits ☒ Yes ☐ No

10e. Street and Number 104 Edge of Town Drive T-2  
10f. Zip Code 21620  
10g. Citizen of What Country? USA

11. Marital Status ☐ Never Married ☒ Married ☐ Widowed ☐ Divorced  
12. Was Decedent Ever in U.S. Armed Forces? ☒ Yes ☐ No  
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ Yes ☒ No Specify:  
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)  
Elementary/Secondary (0-12) 8 College (1-4 or 5+) ☐  
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Farmer  
16b. Kind of Business/Industry Agriculture

17. Father's Name (First, Middle, Last) Wilbur W. Walbert  
18. Mother's Name (First, Middle, Maiden Surname) Beatrice Lehman

19a. Informant's Name/Relationship (Type, Print) Jean Victoria Whitlock Walbert  
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 104 Edge of Town Drive T-2, Chestertown, MD 21620

20a. Method of Disposition ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)  
20b. Place of Disposition (Name of cemetery, crematory or other place) Wesley Cemetery  
20c. Location - City or Town, State 12/20/98 Rock Hall, Maryland

21. Signature of Funeral Service Licensee Kirk J. Helfenbein  
22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A.  
130 Speer Road, Chestertown, MD 21620

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  
Immediate Cause (Final disease or condition resulting in death) Acute Lower GI Bleed  
Due to (or as a consequence of):  
Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last UNKNOWN  
Due to (or as a consequence of):  
Approximate Interval Between Onset and Death Immediate

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  
Severe Diabetes x yes -  
Amputations Both legs -  
23b. Did tobacco use contribute to the cause of death? ☐ Yes ☒ No ☐ Probably ☐ Unknown  
24a. Was an autopsy performed? ☐ Yes ☒ No  
24b. Were autopsy findings available prior to completion of cause of death? ☐ Yes ☒ No

25. Was case referred to medical examiner? ☐ Yes ☒ No  
26. Place of Death (Check only one)  
Hospital: ☐ Inpatient ☒ ER/Outpatient ☐ DOA  
Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death ☒ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending investigation ☐ Could not be determined  
28a. Date of Injury (Month, Day Year)  
28b. Time of Injury M  
28c. Injury at Work? ☐ Yes ☒ No  
28d. Describe how injury occurred  
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier  
29c. License number D36054  
29d. Date signed (Month, Day, Year) 12/17/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 120 SPEER ROAD CHESTERTOWN MD 21620

31. Date filed (Month, Day, Year) DEC 18 1998  
32. Registrar's Signature M. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

08 41398

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) VALENTINA ZACHWALYNSKYJ						2. Date of Death Month Day Year DECEMBER 27, 1998		3. Time of Death 2:30 AM																				
	4a. Facility Name (If not institution, give street and number) MARINER HEALTH CARE OF SILVER SPRING				4b. City, Town, or Location of Death SILVER SPRING		4c. County of Death MONTGOMERY																						
Funeral Director	5. Social Security Number 155-24-6751		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 95 Yrs.		8. Date of Birth (Month, Day, Year) JAN. 27 1903		9. Birthplace (State or Foreign Country) UKRAINE																				
	Usual Residence of Decedent																												
To Be Completed by Funeral Director	10a. State MD		10b. County MONTGOMERY		10c. City, Town or Location SILVER SPRING				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																				
	10e. Street and Number 709 BURNT MILLS CT.				10f. Zip Code 20901		10g. Citizen of What Country? UKRAINE																						
	11. Marital Status 1 <input type="checkbox"/> Navar Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE																					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOME MAKER			16b. Kind of Business/Industry OWN HOME																					
	17. Father's Name (First, Middle, Last) FEDOR POPOV						18. Mother's Name (First, Middle, Maiden Surname) UNOBTAINABLE																						
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) STEPHAN MAKSYMJUK (SON IN LAW)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 709 BURNT MILLS CT. SILVER SPRING, MD 20901																								
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) ST. ANDREWS CHURCH UKRAINIAN ORTHODOX CEMETERY		20c. Location - City or Town, State 12-30-98 SOUTH BOUNDBROOK, NJ																						
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility HINES-RINALDI 11800 NEW HAMPSHIRE AVE. SILVER SPRING, MD 20904																								
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																												
	<table border="0"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a.</td> <td>PNEUMONIA</td> <td rowspan="4">Approximate Interval Between Onset and Death</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td>b.</td> <td>MULTI INFECT DEMENTIA</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td rowspan="4">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>c.</td> <td></td> <td rowspan="4">WEEKS</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> <td></td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death)	a.	PNEUMONIA	Approximate Interval Between Onset and Death	Due to (or as a consequence of):		b.	MULTI INFECT DEMENTIA	Due to (or as a consequence of):		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.		WEEKS	Due to (or as a consequence of):		d.		Due to (or as a consequence of):
Immediate Cause (Final disease or condition resulting in death)	a.	PNEUMONIA	Approximate Interval Between Onset and Death																										
	Due to (or as a consequence of):																												
	b.	MULTI INFECT DEMENTIA																											
	Due to (or as a consequence of):																												
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.		WEEKS																										
	Due to (or as a consequence of):																												
	d.																												
	Due to (or as a consequence of):																												
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. STROKE ; CONGESTIVE HEART FAILURE								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown																					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																									
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred																			
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)																					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																													
29b. Signature and title of certifier <i>[Signature]</i>						29c. License number D08944		29d. Date signed (Month, Day, Year) 12/27/98																					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARTIN C. SHARGEL M.D. 3720 FARRAGUT AVE. KENSINGTON, MD 20895																													
31. Date filed (Month, Day, Year) DEC 29 1998				32. Registrar's Signature <i>[Signature]</i>																									

Handwritten text at the top of the page, possibly a header or introductory paragraph.

Handwritten text in the middle section of the page.

Handwritten text in the lower middle section of the page.

Handwritten text at the bottom of the page, possibly a footer or concluding paragraph.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Item 1 Per PHY Film G767 1-13-99 rja

Reg. No.

98 41399

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Conrey, Brenda L.

Brenda L. Conrey

2. Date of Death

Month 12 Day 28 Year 98

3. Time of Death

0910 AM

4a. Facility Name (If not institution, give street and number)

AGH Atlantic General Hospital

4b. City, Town, or Location of Death

Berlin

4c. County of Death

Worcester

Funeral  
Director

5. Social Security Number  
220-38-1998

6. Sex  
1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)  
56 Yrs.

8. Date of Birth (Month, Day, Year)  
10/30/42

9. Birthplace (State or Foreign Country)  
Wash, D.C.

Usual Residence of Decedent

10a. State  
Md.

10b. County  
Worcester

10c. City, Town or Location

Snow Hill

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

104 N. Collins St.

10f. Zip Code

21863

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Navar Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)  
2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

House counselor

16b. Kind of Business/Industry

Worcester County Development Center

17. Father's Name (First, Middle, Last)

William B. Hardy

18. Mother's Name (First, Middle, Maiden Summa)

Catherine Anderson Hardy

19a. Informant's Name/Relationship (Type, Print)

Michael Conrey

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

104 N. Collins St., Snow Hill, Md. 21863

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Salisbury Crematory

20c. Date

1/1/99

20d. Location - City or Town, State

Salisbury, Md.

21. Signature of Funeral Service Licensee

Patricia L. Dennis

22. Name and Address of Facility

P.O. Box 87  
Dennis Funeral Home, Snow Hill, Md. 21863

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Bronchiogenic CARCINOMA

Due to (or as a consequence of):

Approximate interval Between Onset and Death

8 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated sequence resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

phys 12

29c. License number

H 44283

29d. Date signed (Month, Day, Year)

12/28/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert J. Durkin P.O. 9733 Healthway DR. Berlin MD 21811

31. Date filed (Month, Day, Year)

DEC 29 1998

32. Registrar's Signature

B. Sparks

State Registrar

SS. 220-38-1998  
DOB 10/30/42  
Baltimore, Maryland 21215-0020  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.  
Conrey, Brenda  
12/28/98  
0910  
Division of Vital Records, P.O. Box 68760,  
Baltimore, Maryland 21215-0020





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Item: 4a per M.D G-767 1/13/99 reb

98 41400

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last)

Agnes

Loeschke

2. Date of Death  
Month Day Year  
December 27, 1998

3. Time of Death  
3:10 A.M.

4a. Facility Name (If not institution, give street and number)

32 Turbin Court

4b. City, Town, or Location of Death

Thurmont

4c. County of Death

Frederick

5. Social Security Number  
214-22-5325

8. Sex  
1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)  
101 Yrs.

If Under 1 Year  
Months Days

If Under 24 Hrs.  
Hours Min.

8. Date of Birth (Month, Day, Year)  
November 17, 1897

9. Birthplace (State or Foreign Country)  
Maryland

Usual Residence of Decedent

10a. State  
Maryland

10b. County  
Frederick

10c. City, Town or Location

Thurmont

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number  
32 Turbin Court

10f. Zip Code  
21788

10g. Citizen of What Country?  
U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary (Secondary (0-12)

College (1-4 or 5+)

18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

John Conrad Thomas

18. Mother's Name (First, Middle, Maiden Surname)

Valentina Suchanck

19a. Informant's Name/Relationship (Type, Print)

Mr. Richard J. Loeschke/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2933 Woodwick Court Ellicott City, Maryland 21042

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lorraine Park Cemetery

Date

12/30/98

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Slack Funeral Home, P.A.  
3671 Old Columbia Pike Ellicott City, MD 21043

23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Dehydration/electrolyte imbalance

Due to (or as a consequence of):

Senile dementia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive heart failure  
Generalized osteoarthritis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Brad Cooper M.D.

29c. License number

D22819

29d. Date signed (Month, Day, Year)

12/30/98

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

BRAD J. COOPER, M.D. 52 WATER ST. THURMONT, MD. 21788

31. Date filed (Month, Day, Year)

JAN 13 1999

32. Registrar's Signature

Berna B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Item 24a Per PHY Film G767 1-13-99 rja

Reg. No.

98 41401

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Florence Powell

2. Date of Death

Month Day Year  
December 29, 1998

3. Time of Death

4:15 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

302 S. Pennsylvania Avenue

4b. City, Town, or Location of Death

Delmar

4c. County of Death

Wicomico

5. Social Security Number

214-18-4441

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

91

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Feb. 27, 1907

9. Birthplace (State or Foreign Country)

unknown

Usual Residence of Decedent

10a. State

Maryland

10b. County

Wicomico

10c. City, Town or Location

Delmar

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

302 S. Pennsylvania Avenue

10f. Zip Code

21875

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces? unknown  
1 ☐ Yes 2 ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
UnknownCollege (1-4 or 5+)  
Unknown

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Unknown

16b. Kind of Business/Industry

Unknown

17. Father's Name (First, Middle, Last)

Unknown

18. Mother's Name (First, Middle, Maiden Surname)

Unknown

19a. Informant's Name/Relationship (Type, Print)

Unknown

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Unknown

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☒ Other (Specify) In state

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board, 655 W. Baltimore Street  
Baltimore, Maryland 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. cerebral infarct  
Due to (or as a consequence of):b. Atherosclerosis  
Due to (or as a consequence of):c. Cancer breast  
Due to (or as a consequence of):d.  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

yes.  
yes.  
yes.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension  
Diabetes

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No XXX

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

029749

29d. Date signed (Month, Day, Year)

12/30/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William H Robins 1104 Heathway Dr Salisbury Md 21804

31. Date filed (Month, Day, Year)

JAN 11 1999

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41402

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

SARAH COLLINS

2. Date of Death  
Month Day Year

DEC. 23 1998

3. Time of Death

5:39 am

4a. Facility Name (If not institution, give street and number)

36 LINCOLN PARKWAY

4b. City, Town, or Location of Death

ANNAPOLIS

4c. County of Death

ANNE ARUNDEL

Funeral  
Director

5. Social Security Number

227-07-2520

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

MAY 13 1917

9. Birthplace (State or Foreign Country)

VIRGINIA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ANNE ARUNDEL

10c. City, Town or Location

ANNAPOLIS

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

36 LINCOLN PARKWAY

10f. Zip Code

21401

10g. Citizen of What Country?

US

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12th

2 yrs.

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

DENTAL HYGIENIST

16b. Kind of Business/Industry

DR. WILLIAM COLLINS

17. Father's Name (First, Middle, Last)

ANDREW Y. MERRITT

18. Mother's Name (First, Middle, Maiden Surname)

ETHEL HEWITT

19a. Informant's Name/Relationship (Type, Print)

HANNAH FINNEY (SISTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

36 LINCOLN PARKWAY ANNAPOLIS, MD. 21401

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

METRO CREMATORY

Date

12/29/98 BALTIMORE, MD.

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Larry D. Reese

22. Name and Address of Facility

WM. REESE &amp; SONS MORTUARY, P.A.

821 WEST ST. ANNAPOLIS, MD. 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Profound Dementia

Due to (or as a consequence of):

b. Alzheimer Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1+ year  
years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Recent Stroke with Right Hemiparesis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Peter F. Verschuver

29c. License number

D 11653

29d. Date signed (Month, Day, Year)

Dec. 23, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Peter F. Verschuver MD 2002 MED PARKWAY, Annapolis, MD, 21401

31. Date filed (Month, Day, Year)

DEC 28 1998

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director











Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41404

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Nell Juanita Edwards				2. Date of Death Month Day Year December 22, 1998		3. Time of Death 2:15 PM														
	4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center				4b. City, Town, or Location of Death Annapolis		4c. County of Death Anne Arundel														
Funeral Director	5. Social Security Number 245-16-7829		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (in yrs. last birthday) 81 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) August 17, 1917														
	9. Birthplace (State or Foreign Country) Tennessee																				
Usual Residence of Decedent																					
10a. State Maryland		10b. County Anne Arundel		10c. City, Town or Location Arnold				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No													
10e. Street and Number 190 Camps Green Drive				10f. Zip Code 21012		10g. Citizen of What Country? U. S. A.															
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White														
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) N/A				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sales Person		16b. Kind of Business/Industry B, G & E															
17. Father's Name (First, Middle, Last) George Monroe Fisher				18. Mother's Name (First, Middle, Maiden Surname) Lillie Mae Harper																	
19a. Informant's Name/Relationship (Type, Print) (Daughter) Peggy June Buettner				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 412 Friendship Drive Centerville, Maryland 21617																	
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) Mausoleum			20b. Place of Disposition (Name of cemetery, crematory or other place) Glen Haven Memorial Park		20c. Location - City or Town, State Glen Burnie, Maryland		20d. Date 12/28/1998														
21. Signature of Funeral Service Licensee <i>Michael C. Jaffar</i>				22. Name and Address of Facility Singleton Funeral Home PA 1 Second Avenue S. W. Glen Burnie, Maryland 21061																	
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																					
<table border="0"> <tr> <td rowspan="4">                 Immediate Cause (Final disease or condition resulting in death)                   Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last             </td> <td>a.</td> <td>sepsis</td> <td>days</td> </tr> <tr> <td>b.</td> <td>pneumonia</td> <td>days</td> </tr> <tr> <td>c.</td> <td>chronic respiratory failure</td> <td>years</td> </tr> <tr> <td>d.</td> <td>asbestosis</td> <td>years</td> </tr> </table>									Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	sepsis	days	b.	pneumonia	days	c.	chronic respiratory failure	years	d.	asbestosis	years
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	sepsis	days																		
	b.	pneumonia	days																		
	c.	chronic respiratory failure	years																		
	d.	asbestosis	years																		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. right Thoracoplasty for remote history pulmonary tuberculosis Osteoporosis						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown															
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No														
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28d. Describe how injury occurred																		
28f. Location (Street and Number or Rural Route Number, City or Town, State)																					
29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																					
29b. Signature and title of certifier <i>Rebecca E. ...</i>				29c. License number D41955		29d. Date signed (Month, Day, Year) 12-23-98															
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rebecca E. ... MD 1454 69A Blvd Arnold 21012																					
31. Date filed (Month, Day, Year) DEC 28 1998				32. Registrar's Signature <i>Benita B. ...</i>																	

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

State  
Registrar



98-7680-033

JAMES

FRANKLIN SR.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41405

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LEVI JAMES FRANKLIN SR.				2. Date of Death Month Day Year DECEMBER 31, 1998				3. Time of Death 9:35A.M.		
	4a. Facility Name (If not institution, give street and number) SOUTHERN MARYLAND HOSPITAL CENTER				4b. City, Town, or Location of Death CLINTON				4c. County of Death PRINCE GEORGES		
Funeral Director	5. Social Security Number 217-44-4478	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 51 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) JUNE 27, 1947		9. Birthplace (State or Foreign Country) WASHINGTON, DC			
	Usual Residence of Decedent										
10a. State MARYLAND		10b. County CHARLES		10c. City, Town or Location LA PLATA				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
10e. Street and Number 6265 HUNTT ROAD "P. O. BOX 1944"				10f. Zip Code 20646		10g. Citizen of What Country? UNITED STATES					
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: BLACK				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TRUCK DRIVER			16b. Kind of Business/Industry PRIVATE, BURCH OIL				
17. Father's Name (First, Middle, Last) ANDREW FRANKLIN SR.				18. Mother's Name (First, Middle, Maiden Surname) TRENY (FREEMAN) FRANKLIN							
19a. Informant's Name/Relationship (Type, Print) LUCY FRANKLIN / WIFE				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. BOX 1944 LA PLATA, MARYLAND 20646							
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) TRINITY MEMORIAL GARDENS		Date 1/7/99		20c. Location - City or Town, State WALDORF, MARYLAND					
21. Signature of Funeral Service Licensee <i>Lydia C. Thornton Johnson</i> LYDIA C. THORNTON JOHNSON				22. Name and Address of Facility THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD INDIAN HEAD, MD 20640							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  a. <u>Multiple injuries</u> Due to (or as a consequence of):  b. _____ Due to (or as a consequence of):  c. _____ Due to (or as a consequence of):  d. _____  Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
								24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) 12 31 98		28b. Time of Injury 0905A M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred DRIVEN OVER CAR COLLIDED WITH TRUCK			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ROAD ONLY				28f. Location (Street and Number or Rural Route Number, City or Town, State) 301 + CEDARVIEW RD PRINCE GEORGES COUNTY					
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier <i>Blayne D. White</i>				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) JANUARY 1, 1999					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HARRY DAVIS B. KORSHAN JR. 111 Penn Street, Baltimore, Maryland 21201											
31. Date filed (Month, Day, Year) JAN 04 1999		32. Registrar's Signature <i>[Signature]</i>									



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41406

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mary Margaret Fox				2. Date of Death Month Day Year Dec. 26, 1998				3. Time of Death 6:50 pm	
	4a. Facility Name (If not institution, give street and number) Genesis Eldercare				4b. City, Town, or Location of Death Severna Park				4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 316-16-7596		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 75 Yrs.		8. Date of Birth (Month, Day, Year) April 13, 1923		9. Birthplace (State or Foreign Country) Indiana	
	Usual Residence of Decedent				10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Severna Park	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 709 Laurel Lane				10f. Zip Code 21146		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry Home			
	17. Father's Name (First, Middle, Last) William Roth				18. Mother's Name (First, Middle, Maiden Surname) Gertrude Senn					
	19a. Informant's Name/Relationship (Type, Print) Kevin Fox / Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 711 Laurel Lane Severna Park, MD 21146					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MD Veterans Cemetery		Date Dec 30 1998		20c. Location - City or Town, State Crownsville, MD			
	21. Signature of Funeral Service Licensee <i>Robert J. Barranco</i>				22. Name and Address of Facility Barranco & Sons P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy. Severna Park, MD 21146					
	23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. <i>sepsis</i> Due to (or as a consequence of): f. <i>pneumonia</i> Due to (or as a consequence of): g. <i>dysphagia</i> Due to (or as a consequence of): h. <i>advanced Alzheimers Disease</i>									
	Approximate Interval Between Onset and Death hours days months years									
	Physician /Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
State Registrar	29b. Signature and title of certifier <i>Rebecca Eton MD</i>				29c. License number D41955				29d. Date signed (Month, Day, Year) 12-28-98	
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Rebecca Eton MD 1454 B+A Blvd Arnold MD 21012									
	31. Date filed (Month, Day, Year) DEC 29 1998				32. Registrar's Signature <i>James S. Sparks</i>					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **98 41407**  
Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last) <b>Helen Augusta Gross</b>				2. Date of Death Month <b>Dec</b> Day <b>27</b> Year <b>1998</b>				3. Time of Death <b>1322</b>	
4a. Facility Name (If not institution, give street and number) <b>Anne Arundel Medical Center</b>				4b. City, Town, or Location of Death <b>Annapolis</b>				4c. County of Death <b>Anne Arundel</b>	
5. Social Security Number <b>219 16 1512</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>86</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>10/15/1912</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>	

Funeral  
Director

To Be Completed by Funeral Director

Usual Residence of Decedent				10a. State <b>MD</b>				10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Annapolis</b>		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number <b>1010 Tallwood Road #TC</b>				10f. Zip Code <b>21403</b>				10g. Citizen of What Country? <b>USA</b>					
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Dietician</b>				16b. Kind of Business/Industry <b>State Of Maryland</b>					
17. Father's Name (First, Middle, Last) <b>Thomas Dorsey</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Isabella Hesse</b>							
19a. Informant's Name/Relationship (Type, Print) <b>Frank Simms (son)</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1010 Tallwood Rd #TC/Annapolis MD 21401</b>							
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metropolitan Crematory</b>		Date <b>12/30/98</b>		20c. Location - City or Town, State <b>Alexandria VA</b>					
21. Signature of Funeral Service Licensee <b>Melanie Wilhelm Hagon</b>				22. Name and Address of Facility <b>Advent Funeral &amp; Cremation Services Annapolis MD 21401</b>									

Physician  
/Medical  
Examiner

To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Myocardial infarction</b> Due to (or as a consequence of): <b>Hypertension</b> Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>1 hour Many years</b>				23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
23c. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							

25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28d. Describe how Injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							

29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <b>Robert Scott Eden, MD</b>			
29c. License number <b>30701</b>				29d. Date signed (Month, Day, Year) <b>12/30/98</b>			

30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>ROBERT SCOTT EDEN, MD, 600 RIDGELY AVE., ANNAPOLIS, MD 21401</b>			
31. Date filed (Month, Day, Year) <b>DEC 31 1998</b>		32. Registrar's Signature <b>B. Sparks</b>	

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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Amend. #14 1/7/99 AM AACO Health  
Amend. #20b 12/30/98 SM AACO Health

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41408

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MALCOLM (NMN) HARRISON</b>		2. Date of Death Month Day Year <b>DECEMBER 22, 1998</b>		3. Time of Death <b>9:00 P.M.</b>
	4a. Facility Name (If not institution, give street and number) <b>8 IVY LANE</b>		4b. City, Town, or Location of Death <b>GLEN BURNIE</b>		4c. County of Death <b>ANNE ARUNDEL</b>
Funeral Director	5. Social Security Number <b>417-32-2831</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>73</b> Yrs.	If Under 1 Year Months Days <b>10/24/25</b>	8. Date of Birth (Month, Day, Year) <b>10/24/25</b>
	9. Birthplace (State or Foreign Country) <b>ALABAMA</b>				
Usual Residence of Decedent					
10a. State <b>MD</b>		10b. County <b>ANNE ARUNDEL</b>		10c. City, Town or Location <b>GLEN BURNIE</b>	
10e. Street and Number <b>8 IVY LANE</b>		10f. Zip Code <b>21061</b>		10g. Citizen of What Country? <b>UNITED STATES</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1949-74</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b> <del>WHITE</del>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (14 or 5+) <b>SECURITY</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business/Industry <b>DEPT. OF DEFENSE</b>	
17. Father's Name (First, Middle, Last) <b>JIM HARRISON</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>CALLIE SMITH</b>			
19a. Informant's Name/Relationship (Type, Print) <b>NATASHA CASSANDRA HARRISON (DAUGHTER)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>103 90 FAULKNER RIDGE CIR., COLUMBIA MD, 21044</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MD VETERANS CEMETERY</b>		20c. Location - City or Town, State <b>12/29/98 12/31/98 CROWNSVILLE, MD</b>	
21. Signature of Funeral Service Licensee <i>Richard C. Gaffan</i>		22. Name and Address of Facility <b>SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061</b>			
23a. Part I. Enter the disease, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death) a. <i>myocardial infarction</i> Due to (or as a consequence of):					
b. <i>CAD</i> Due to (or as a consequence of):					
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of):					
d. Due to (or as a consequence of):					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Htn, diabetes, chronic aneurysm, chronic renal insufficiency, Cardiomyopathy.</i>					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <i>Michael M.D.</i>		29c. License number <b>32118</b>		29d. Date signed (Month, Day, Year) <b>12-23-98</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>KASHI PATIL 3100 WYMAN PARK DRIVE BALD MD 21211</b>					
31. Date filed (Month, Day, Year) <b>DEC 28 1998</b>		32. Registrar's Signature <i>B. Smith</i>			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

88 41409

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>KATHERINE LOUISE MCKINLEY</b>			2. Date of Death Month Day Year <b>DECEMBER 28, 1998</b>		3. Time of Death <b>7:45 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>CROFTON NURSING HOME</b>			4b. City, Town, or Location of Death <b>CROFTON</b>		4c. County of Death <b>ANNE ARUNDEL</b>	
Funeral Director	5. Social Security Number <b>214-16-3533</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>95</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>JAN. 8, 1903</b>
	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>						
Usual Residence of Decedent							
10a. State <b>MARYLAND</b>		10b. County <b>ANNE ARUNDEL</b>		10c. City, Town or Location <b>PASADENA</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>3 WEST PASADENA ROAD</b>				10f. Zip Code <b>21122</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6TH</b> College (1-4or 5+) <b>N/A</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOMEMAKER</b>		16b. Kind of Business/Industry <b>OWN HOME</b>	
17. Father's Name (First, Middle, Last) <b>EDWARD ELLIOTT</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>DERNA MOORE</b>			
19a. Informant's Name/Relationship (Type, Print) <b>PEGGY BENTON (DAUGHTER)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3 WEST PASADENA ROAD, PASADENA, MD. 21122</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>GLEN HAVEN MEMORIAL PARK</b>		20c. Location - City or Town, State <b>12/31/98 GLEN BURNIE, MD.</b>	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>SINGLETON FUNERAL HOME, P.A. 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061</b>			
23a. Part I. Enter the disease or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. End Stage Alzheimers disease</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>							
Approximate Interval Between Onset and Death <b>10 year</b>							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and Title of certifier 		29c. License number <b>D 22028</b>		29d. Date signed (Month, Day, Year) <b>12 29 98</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Paul S Rhodes MD 1667 Crofton Centre Crofton Md</b>							
31. Date filed (Month, Day, Year) <b>DEC 30 1998</b>		32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1997-1998



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

38 41410

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Mildred Myers</b>				2. Date of Death Month Day Year <b>Dec. 28th 1998</b>		3. Time of Death <b>10:30AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>Anne Arundel Medical Center</b>				4b. City, Town, or Location of Death <b>Annapolis</b>		4c. County of Death <b>Anne Arundel</b>		
Funeral Director	5. Social Security Number <b>214-62-2455</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>95</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>June 20, 1903</b>		
	9. Birthplace (State or Foreign Country) <b>Annapolis</b>								
Usual Residence of Decedent									
10a. State <b>Maryland</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Annapolis</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>105 Conduit Street</b>				10f. Zip Code <b>21401</b>		10g. Citizen of What Country? <b>United States</b>			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Home Maker</b>		16b. Kind of Business/Industry <b>own home</b>			
17. Father's Name (First, Middle, Last) <b>Louis Thomas</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Sophia Basil</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Nancy Ruddell (daughter)</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>14 Cathedral St. Annapolis, MD 21401</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Cedar bluff Cemetery</b>		20c. Location - City or Town, State <b>12/31/98 Annapolis, Maryland</b>				
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility <b>John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401</b>				
23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Congestive Heart Failure</b> Due to (or as a consequence of): <b>b. Acute Myocardial Infarct</b> Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):								Approximate Interval Between Onset and Death <b>5 days</b> <b>5 days</b>	
23b. Pert 2. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Diabetes</b> <b>Hypertension</b>								23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred				28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier 				29c. License number <b>D18529</b>		29d. Date signed (Month, Day, Year) <b>12-28-98</b>			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Jon B. Lowe, MD, 2007 Tidewater Colony Dr, Suite 2A, Annapolis, MD 21401</b>									
31. Date filed (Month, Day, Year) <b>DEC 29 1998</b>				32. Registrar's Signature 					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 4 14 11

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Carl Rodney Owens

2. Date of Death

Month Day Year  
Dec 22 1998

3. Time of Death

1035 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Anne Arundel General Hospital

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

AA

5. Social Security Number

214-66-0758

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

44

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

APRIL 22 1954 WASH. D.C.

9. Birthplace (State or Foreign Country)

Usual Residence of Decedent

10a. State

MARYLAND ANNE ARUNDEL

10b. County

10c. City, Town or Location

LOTHIAN

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1208 WHITTINGTON DRIVE

10f. Zip Code

20711

10g. Citizen of What Country?

US

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12th

0

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

BODY &amp; FENDER

16b. Kind of Business/Industry

COUNTY CHRYSLER

17. Father's Name (First, Middle, Last)

JOHN E. OWENS

18. Mother's Name (First, Middle, Maiden Surname)

IRENE E. COLE

19a. Informant's Name/Relationship (Type, Print)

EDNA OWENS (SISTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1208 WHITTINGTON DR. LOTHIAN, MD. 20711

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MOSES CEMETERY

Date

12/28/98

20c. Location - City or Town, State

DRURY, MD.

21. Signature of Funeral Service Licensee

Larry S. Reese

22. Name and Address of Facility

WM. REESE &amp; SONS MORTUARY, P.A.

821 WEST ST. ANNAPOLIS, MD. 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute Cardiac Insufficiency

Due to (or as a consequence of):

UNK

b. Arteriosclerotic Heart Disease

Due to (or as a consequence of):

UNK

c. Hypertension

Due to (or as a consequence of):

Years

d. Diabetes Mellitis

Years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

William P. Jones, M.D.

29c. License number

D 06054

29d. Date signed (Month, Day, Year)

12-22-1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William P. Jones, M.D. 6131 Shady Side Road Shady Side, MD 20764

31. Date filed (Month, Day, Year)

DEC 28 1998

32. Registrar's Signature

Anne S. Spahr

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41412

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CHARLES RESCH JR.

2. Date of Death  
Month Day Year

DECEMBER 21 1998

3. Time of Death

1:55pm

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

HARBOR HOSPITAL CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

217-05-4550

6. Sex  
1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year  
Months DaysIf Under 24 Hrs.  
Hours Min.8. Date of Birth  
(Month, Day, Year)

NOV. 17, 1919

9. Birthplace (State or Foreign  
Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ANNE ARUNDEL

10c. City, Town or Location

GLEN BURNIE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7830 OAKWOOD ROAD

10f. Zip Code

21061

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?1 ☒ Yes 2 ☐ No 1942-  
If Yes, Give  
Year or Dates: 194513. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

MASTER ELECTRICIAN

16b. Kind of Business/Industry

ELECTRICAL CONTRACTOR

17. Father's Name (First, Middle, Last)

CHARLES

RESCH, SR.

18. Mother's Name (First, Middle, Maiden Surname)

EUNICE MADELENE MICHAELS

19a. Informant's Name/Relationship (Type, Print)

IRMA M. RESCH (WIFE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7830 OAKWOOD ROAD, GLEN BURNIE, MARYLAND 21061

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

GLEN HAVEN MEMORIAL PARK

Date

12/28/98 GLEN BURNIE, MD.

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SINGLETON FUNERAL HOME, P.A.,  
1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 2106123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. WIDESPREAD METASTATIC MESOTHELIOMA

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
2 ☐ Accident investigation  
3 ☐ Suicide 6 ☐ Could not be  
4 ☐ Homicide determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)
☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Avinash L. Ganti - INTERN

29c. License number

P12795

29d. Date signed (Month, Day, Year)

DECEMBER 21 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AVINASH L. GANTI 3001 SOUTH HANOVER STREET, BALTIMORE MD 21225

31. Date filed (Month, Day, Year)

DEC 28 1998

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 41413

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Margaret Eleanor Swisher					2. Date of Death Month Day Year Dec 25 1998		3. Time of Death 1815		
	4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center					4b. City, Town, or Location of Death Annapolis		4c. County of Death Anne Arundel		
Funeral Director	5. Social Security Number 578 05 8191		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 87 Yrs.		8. Date of Birth (Month, Day, Year) Jan 4 / 1911		9. Birthplace (State or Foreign Country) Washington DC	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Annapolis			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 103 Fogel Drive				10f. Zip Code 21403			10g. Citizen of What Country? USA		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Bookkeeper			16b. Kind of Business/Industry Accounting		
	17. Father's Name (First, Middle, Last) Raymond E. Grove					18. Mother's Name (First, Middle, Maiden Surname) Eleanor Erin McKevitt				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Donna Lee Smith (daughter)					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 103 Fogel Drive/Annapolis MD 21403				
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory			Date 12/29/98		20c. Location - City or Town, State Alexandria VA	
	21. Signature of Funeral Service Licensee Melanie Wilhelm-Nguyen					22. Name and Address of Facility Advent Funeral & Cremation Services Annapolis MD 21401				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute Intracerebral Hemorrhage Due to (or as a consequence of): b. Hypertension Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
State Registrar	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Osteoporosis									
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit document.	29b. Signature and title of certifier Charles P. Adamo MD					29c. License number D-18566		29d. Date signed (Month, Day, Year) 12/29/98		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles P. Adamo MD 180 Admiral Cochrane, Annapolis, MD									
31. Date filed (Month, Day, Year) DEC 31 1998										
32. Registrar's Signature [Signature]										





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MILDRED R. STEPHENS</b>				2. Date of Death Month Day Year <b>Dec. 26 1998</b>		3. Time of Death <b>7:26 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>631 Teton Ct.</b>				4b. City, Town, or Location of Death <b>Lothian</b>		4c. County of Death <b>Anne Arundel</b>	
Funeral Director	5. Social Security Number <b>219-36-2191</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>77</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Oct. 14, 1921</b>	9. Birthplace (State or Foreign Country) <b>Massachusetts</b>
	Usual Residence of Decedent							
10e. State <b>Md.</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Lothian</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>631 Teton Ct.</b>				10f. Zip Code <b>20711</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>1</b> College (1-4or 5+) <b>1</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Purchasing Agent</b>		16b. Kind of Business/Industry <b>U.S. Navy</b>		
17. Father's Name (First, Middle, Last) <b>Arthur E. Rutledge</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Nora Connelly</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Ann Nazzaro (Sister)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>74 Holyoak St. Malden, MA 02148</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Hillcrest Cemetery</b>		Date <b>12/29/98</b>		20c. Location - City or Town, State <b>Annapolis, Md.</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>John M. Taylor Funeral Home Inc. 147 Duke of Gloucester St. Annapolis, Md. 21401</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Acute Myocardial Infarction</b> Due to (or as a consequence of): <b>Non insulin dependent diabetes</b> Due to (or as a consequence of): <b>Hypercholesterolemia</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>5 years</b> <b>Lifetime</b>								Approximate interval Between Onset and Death <b>Immediate</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)		28b. Time of injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>DC 13077</b>		29d. Date signed (Month, Day, Year) <b>Dec. 28, 1998</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Ellen D. Finkelman, M.D. 2150 Pennsylvania Ave. NW Washington D.C. 20037</b>								
31. Date filed (Month, Day, Year) <b>DEC 29 1998</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Small amount

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 41415

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Thomas Shaffer</b>		2. Date of Death Month <b>Dec</b> Day <b>25</b> Year <b>98</b>		3. Time of Death <b>1053AM</b>	
4a. Facility Name (If not institution, give street and number) <b>Anne Arundel Gen. Hospital</b>		4b. City, Town, or Location of Death <b>Annapolis</b>		4c. County of Death <b>AA</b>	
5. Social Security Number <b>214-70-1614</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>41</b> Yrs.	
8. Date of Birth (Month, Day, Year) <b>Oct. 8, 1957</b>		9. Birthplace (State or Foreign Country) <b>Washington D.C.</b>			
Usual Residence of Decedent					
10a. State <b>MD</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Arnold</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>1645 Bald Eagle Road</b>		10f. Zip Code <b>21012</b>	
10g. Citizen of What Country? <b>USA</b>		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12+</b> College (1-4 or 5+) <b>5+</b>	
16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Software Engineer</b>		17. Decedent's Kind of Business/Industry <b>Computer Science</b>		18. Decedent's Name (First, Middle, Maiden Surname) <b>Molly Smith</b>	
19. Informant's Name/Relationship (Type, Print) <b>Janine Shaffer, wife</b>		20. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1645 Bald Eagle Road Arnold, MD 21012</b>		21. Signature of Funeral Service Licensee <b>[Signature]</b>	
22. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		23. Place of Disposition (Name of cemetery, crematory or other place) <b>Asbury United Methodist Church Cemetery</b>		24. Date <b>Dec 30 1998</b>	
25. Location - City or Town, State <b>Arnold, MD</b>		26. Name and Address of Facility <b>Barranco &amp; Sons P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy. Severna Park, MD 21146</b>		27. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>a. Acute Cardiac Arrhythmia minutes</b> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):	
28. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		29. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		30. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
31. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		32. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		33. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
34. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		35. Date of Injury (Month, Day Year) <b>28a. Date of Injury (Month, Day Year)</b>		36. Time of Injury <b>28b. Time of Injury M</b>	
37. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		38. Describe how Injury occurred <b>28d. Describe how Injury occurred</b>		39. Location (Street and Number or Rural Route Number, City or Town, State) <b>28f. Location (Street and Number or Rural Route Number, City or Town, State)</b>	
40. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		41. Signature and title of certifier <b>William P. Jones, MD Deputy</b>		42. License number <b>DD06054</b>	
43. Date signed (Month, Day, Year) <b>12-25-98</b>		44. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>William P. Jones, MD 695 America 21035</b>		45. Date filed (Month, Day, Year) <b>DEC 29 1998</b>	
46. Registrar's Signature <b>[Signature]</b>		47. State Registrar		48. DHMH 16 Rev 6/95	

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41416

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) John L. Saveleski				2. Date of Death Month 12 Day 23 Year 98		3. Time of Death 1930		
	4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center				4b. City, Town, or Location of Death Annapolis		4c. County of Death Anne Arundel		
Funeral Director	5. Social Security Number 199-30-3067		8. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 57 Yrs.		6. Date of Birth (Month, Day, Year) Aug 28, 1941		
	Usual Residence of Decedent		10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Annapolis		
		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 1288 Cape Saint Claire Road		10f. Zip Code 21401		10g. Citizen of What Country? USA	
		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1961-1965		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Mechanical Engineer Technician Federal Government		16b. Kind of Business/Industry			
		17. Father's Name (First, Middle, Last) John M. Saveleski				18. Mother's Name (First, Middle, Maiden Surname) Margaret I. Helmstetter			
		19a. Informant's Name/Relationship (Type, Print) Lois A. Saveleski / Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1288 Cape Saint Claire Rd. Annapolis, MD 21401			
		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veterans Cemetery		Date Dec. 28 1998		20c. Location - City or Town, State Crownsville, MD	
		21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility Barranco & Sons P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy., Severna Park, MD 21146					
		23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  a. <i>Cardiac arrest</i> Due to (or as a consequence of):  b. <i>Brain stem stroke</i> Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):						Approximate Interval Between Onset and Death 20 mins 48 hours	
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) NONE		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
				28d. Describe how injury occurred		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
		29b. Signature and title of certifier <i>[Signature]</i>		29c. License number D13243		29d. Date signed (Month, Day, Year) 12.23.98			
		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) PETER SCHILDER 104 FORBES ST STE 104 ANNAPOLIS MD 21401							
		31. Date filed (Month, Day, Year) DEC 29 1998		32. Registrar's Signature <i>[Signature]</i>					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41417

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Lemuel Jarrett Thomas

2. Date of Death

December 31, 1998

3. Time of Death

10<sup>20</sup> PM

4a. Facility Name (If not institution, give street and number)

GENESIS ELDER CARE

4b. City, Town, or Location of Death

LA PLATA

4c. County of Death

CHARLES

Funeral  
Director

5. Social Security Number

217-18-5769

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

76

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

JULY 27, 1922

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

CHARLES

10c. City, Town or Location

NEWBURG

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

P.O. BOX 25

10f. Zip Code

20664

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
7th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

BUILDING SERVICE WORKER

16b. Kind of Business/Industry

CHARLES COUNTY BOARD OF EDUCATION

17. Father's Name (First, Middle, Last)

JARRIETT THOMAS

18. Mother's Name (First, Middle, Maiden Surname)

MYRTLE WHEELER THOMAS

19a. Informant's Name/Relationship (Type, Print)

MARY THOMAS / WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. BOX 25 NEWBURG, MARYLAND 20664

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

SHILOH CHURCH CEMETERY

Date

1/5/99

20c. Location - City or Town, State

NEWBURG, MARYLAND

21. Signature of Funeral Service Licensee

LYDIA C. THORNTON JOHNSON

22. Name and Address of Facility

THORNTON FUNERAL HOME, P.A.  
3439 LIVINGSTON ROAD INDIAN HEAD, MD 20640

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e.

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia

atrial Fibrillation

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Verifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Michael A. Leatherwood, MD

29c. License number

D0021031

29d. Date signed (Month, Day, Year)

1/1/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Michael A. Leatherwood, MD 700 Olde Line Center Waldorf, Maryland

31. Date filed (Month, Day, Year)

JAN 04 1999

32. Registrar's Signature

S. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Etta Viola Ward</b>				2. Date of Death Month Day Year <b>Dec. 27th 1998</b>		3. Time of Death <b>9:30 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>610 Americana Drive</b>				4b. City, Town, or Location of Death <b>Annapolis</b>		4c. County of Death <b>Anne Arundel</b>	
Funeral Director	5. Social Security Number <b>214-05-1659</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>86</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>May 26th 1912</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Annapolis</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>610 Americana Drive</b>				10f. Zip Code <b>21403</b>		10g. Citizen of What Country? <b>United States</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Sales Person</b>		16b. Kind of Business/Industry <b>Stationary Store</b>		
17. Father's Name (First, Middle, Last) <b>William Charles Benning</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Georgetta Deale</b>				
19a. Informant's Name/Relationship (Type, Print) <b>William G. Phelps Jr. / Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>453 Apt. 313 Shore Acres Rd. Arnold, Maryland 21012</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metropolitan Crematory</b>		Date <b>12/29/98</b>		20c. Location - City or Town, State <b>Alexandria, VA.</b>		
1. Signature of Funeral Service Licensee <i>Harold S. Lytle</i>				22. Name and Address of Facility <b>John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD. 21401</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. <i>arrhythmia</i></b> Due to (or as a consequence of): <b>b. <i>Coronary Artery Disease</i></b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>HBP</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <i>William A. Jones</i>				29c. License number <b>D24762</b>		29d. Date signed (Month, Day, Year) <b>12/28/98</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Phelps Wm. A. 2200 Defense Highway Crofton, Md</b>								
31. Date filed (Month, Day, Year) <b>DEC 29 1998</b>				32. Registrar's Signature <i>James B. Sparks</i>				

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

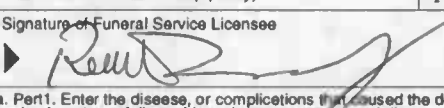
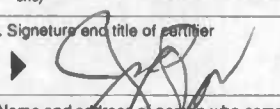
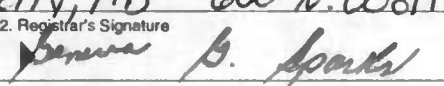
*[Faint, illegible handwritten notes]*

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>William</u>				2. Date of Death Month <u>December</u> Day <u>26</u> Year <u>1998</u>				3. Time of Death <u>7:02am</u>	
	4a. Facility Name (If not institution, give street and number) <u>THE JOHNS HOPKINS HOSPITAL</u>				4b. City, Town, or Location of Death <u>BALTIMORE CITY</u>				4c. County of Death	
Funeral Director	5. Social Security Number <u>420-32-4290</u>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <u>70</u> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) <u>Feb. 23, 1928</u>	9. Birthplace (State or Foreign Country) <u>North Carolina</u>			
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <u>MD</u>	10b. County <u>Anne Arundel</u>	10c. City, Town or Location <u>Severna Park</u>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	10e. Street and Number <u>417 Ben Oaks Drive East</u>				10f. Zip Code <u>21146</u>		10g. Citizen of What Country? <u>USA</u>			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <u>1950-1952</u>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>White</u>			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12+</u> College (14 or 5+) <u>4</u>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Utilities Engineer</u>				16b. Kind of Business/Industry <u>Whiskey Distillers</u>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <u>William V. Wheeler, Sr.</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>Esther Burnett</u>					
	19a. Informant's Name/Relationship (Type, Print) <u>Jane Wheeler / Wife</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>417 Ben Oaks Drive East, Severna Park, MD 21146</u>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>MD Veterans Cemetery</u>		Date <u>Dec. 29 1998</u>		20c. Location - City or Town, State <u>Crownsville, MD</u>			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <u>Barranco &amp; Sons P.A. Severna Park Funeral Home</u> <u>495 Gov. Ritchie Hwy. Severna Park, MD 21146</u>					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
	Immediate Cause (Final disease or condition resulting in death) a. <u>Myocardial Infarction</u> Due to (or as a consequence of):									
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. <u>Pericarditis</u> Due to (or as a consequence of):									
	c. <u>Sepsis</u> Due to (or as a consequence of):									
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown									
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
To Be Completed by Physician/Medical Examiner	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <u>N/A</u>		28b. Time of Injury <u>M</u>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)									
	28f. Location (Street and Number or Rural Route Number, City or Town, State)									
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	29b. Signature and title of certifier 				29c. License number <u>Res-000</u>		29d. Date signed (Month, Day, Year) <u>December 26, 1998</u>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Jason Sperry, MD 600 N. Wolfe Str. Baltimore, MD 21287</u>									
	31. Date filed (Month, Day, Year) <u>DEC 29 1998</u>		32. Registrar's Signature 							



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State of Maryland / Department of Health and Mental Hygiene

98 41420

Amend #26 12/29/98 Sm AACO Health

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Elizabeth Mary Warrington				2. Date of Death Month Day Year December 21, 1998		3. Time of Death 11:15am		
	4a. Facility Name (If not Institution, give street and number) 900 Bestgate Road, Suite 300				4b. City, Town, or Location of Death Annapolis		4c. County of Death Anne Arundel		
Funeral Director	5. Social Security Number 197-18-3289		8. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 73 Yrs.		6. Date of Birth (Month, Day, Year) March 1, 1925		
	9. Birthplace (State or Foreign Country) Pennsylvania		10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Arnold		
Usual Residence of Decedent		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 352 Buena Vista Avenue		10f. Zip Code 21012		10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerk		16b. Kind of Business/Industry Pharmacy					
17. Father's Name (First, Middle, Last) John Kearns				18. Mother's Name (First, Middle, Maiden Surname) Elizabeth McGurk					
19a. Informant's Name/Relationship (Type, Print) Ernest Oehm / son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 352 Buena Vista Avenue, Arnold, MD 21012					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Memorial Park		Date Dec 28 1998		20c. Location - City or Town, State Elkridge, MD			
21. Signature of Funeral Service Licensee		22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy., Severna Park, MD 21146							
23a. Part I. Enter the disease, or combination of diseases, that caused death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Lung cancer Due to (or as a consequence of): Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):		Approximate Interval Between Onset and Death 7 mos.							
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Doctor's Office		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier J. Selouch		29c. License number D19838		29d. Date signed (Month, Day, Year) 12/21/98			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stuart E. Selouch, M.D.		31. Date filed (Month, Day, Year) DEC 29 1998		32. Registrar's Signature B. Sparks		33. Address of person who completed cause of death (Item 23a) (Type, Print) 900 Bestgate Annapolis, Md. 21401			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the problem and the objectives of the research.

2. The second part of the report is a detailed description of the methods used in the study. It includes a discussion of the experimental design, the data collection procedures, and the statistical analysis techniques.

3. The third part of the report is a presentation of the results of the study. It includes a discussion of the findings, a comparison of the results with previous research, and a conclusion about the significance of the study.

4. The fourth part of the report is a discussion of the implications of the study. It includes a discussion of the limitations of the study and suggestions for future research.

5. The fifth part of the report is a list of references. It includes a list of the books, articles, and other sources used in the study.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41421

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Sharon Sue Abrams

2. Date of Death  
Month Day Year

December 27, 1998

3. Time of Death

2108

4a. Facility Name (If not institution, give street and number)

Harford Memorial Hospital

4b. City, Town, or Location of Death

Havre de Grace

4c. County of Death

Harford

Funeral  
Director

5. Social Security Number

218-70-2715

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

42

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Aug. 16, 1956

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Cecil

10c. City, Town or Location

Port Deposit

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

12 Benjamin Park Drive, P.O. Box 23

10f. Zip Code

21904

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
Twelve Years

College (1-4 or 5+)

-----

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Nursing Assistant

16b. Kind of Business/Industry

V.A. Medical Center  
Perry Point, Maryland

17. Father's Name (First, Middle, Last)

Lacy Edwin Short

18. Mother's Name (First, Middle, Maiden Summa)

Cora Lee Whistlehunt

19a. Informant's Name/Relationship (Type, Print)

Samuel E. Abrams, Jr. (husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12 Benjamin Park Dr., P.O. Box 23, Port Deposit, MD 21904

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hopewell Cemetery

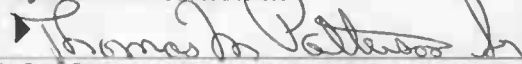
Date

12/31/98

20c. Location - City or Town, State

Port Deposit, Maryland

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Lee A. Patterson & Son Funeral Home  
Perryville, Maryland 21903-0188

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. LUNG CANCER

Due to (or as a consequence of):

b. MALIGNANT PLEURAL EFFUSION 8 MONTHS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

8 MONTHS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ANEMIA, CACHEXIA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

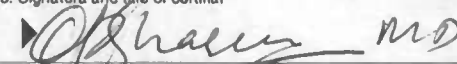
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

 MD

29c. License number

D31856

29d. Date signed (Month, Day, Year)

12/29/1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1814 BELAIR RD FOLSTON MD 21047

State  
Registrar

31. Date filed (Month, Day, Year)

DEC 30 1998

32. Registrar's Signature



ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41422

1. Decedent's Name (First, Middle, Last) <b>Michael Blendy</b>		2. Date of Death Month <b>December</b> Day <b>30</b> Year <b>1998</b>		3. Time of Death <b>0201</b>	
4a. Facility Name (If not institution, give street and number) <b>Union Hospital</b>			4b. City, Town, or Location of Death <b>Elkton</b>		4c. County of Death <b>Cecil</b>
5. Social Security Number <b>159-09-1606</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>81</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
8. Date of Birth (Month, Day, Year) <b>November 15, 1917</b>		9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>			
10a. State <b>Maryland</b>		10b. County <b>Cecil</b>		10c. City, Town or Location <b>Elkton</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number <b>41 Norman Allen Street</b>			10f. Zip Code <b>21921</b>		10g. Citizen of What Country? <b>United States</b>
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>WWII</b> If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Heavy Equipment Operator</b>		16b. Kind of Business/Industry <b>Wharf - Dockbuilders-Pile Drivers Local</b>	
17. Father's Name (First, Middle, Last) <b>Stephen Blendy</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Tekla Cebrick</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Tillie A. Blendy/ Wife</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>41 Norman Allen Street, Elkton, Maryland 21921</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Saint Rose of Lima Cemetery</b>		20c. Location - City or Town, State <b>January 2, Chesapeake City, Maryland</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Hicks Home for Funerals, P.A. 103 West Stockton Street, Elkton, Maryland 21921</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Septic Shock</b> Due to (or as a consequence of): b. <b>Pneumonia</b> Due to (or as a consequence of): c. <b>CHF and COPD</b> Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
Approximate Interval Between Onset and Death					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Ischemic Cardiomyopathy</b> <b>Left Hip Fracture</b> <b>Hypertensive Dehydration</b> <b>Acute and Chronic Renal Failure</b> <b>Attical Embolization</b>					
23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number <b>A30291</b>		29d. Date signed (Month, Day, Year) <b>12/30/98</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Robert Denitzio M.D. 111 West High Street, Elkton, Maryland 21921</b>					
31. Date filed (Month, Day, Year) <b>JAN 04 1999</b>		32. Registrar's Signature 			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41423

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Laura Kealy Chidester

2. Date of Death

Month Day Year  
December 30, 1998

3. Time of Death

0748

4a. Facility Name (If not institution, give street and number)

Sunrise Care and Rehabilitation

4b. City, Town, or Location of Death

Elkton

4c. County of Death

Cecil

Funeral  
Director

5. Social Security Number

214-26-5488

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

69 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
May 18, 1929

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Cecil

10c. City, Town or Location

North East

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

303 Old Zion Road

10f. Zip Code

21901

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

18b. Kind of Business/Industry

in her own home

17. Father's Name (First, Middle, Last)

Thomas Widdoes

18. Mother's Name (First, Middle, Maiden Surname)

Olga Kristiane Olsen

19a. Informant's Name/Relationship (Type, Print)

Austin C. Chidester/ Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

303 Old Zion Road, North East, Maryland 21901

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gilpin Manor  
Memorial Park

Date

January 2,  
1999

20c. Location - City or Town, State

Elkton, Maryland

21. Signature of Funeral Service Licensee

Dana S. Hicks

22. Name and Address of Facility

Hicks Home for Funerals, P.A.

103 West Stockton Street, Elkton, Maryland 21921

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CEREBROVASCULAR ACCIDENT

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 MONTH

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. ATRIAL FIBRILLATION

Due to (or as a consequence of):

1 MONTH

c. MYOCARDIAL INFARCTION

Due to (or as a consequence of):

1 MONTH

d. ARTERIO SCLEROSIS

1 MONTH

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Rolando A. Najera, M.D.

29c. License number

D07463

29d. Date signed (Month, Day, Year)

12-30-98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rolando A. Najera M.D. 111 West High Street, Elkton, Maryland 21921

31. Date filed (Month, Day, Year)

JAN 04 1999

32. Registrar's Signature

Benjamin B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Elsie Veronica Craig

2. Date of Death

Month Day Year  
December 27, 1998

3. Time of Death

0230

4a. Facility Name (If not institution, give street and number)

Harford Memorial Hospital

4b. City, Town, or Location of Death

Havre de Grace

4c. County of Death

Harford

Funeral  
Director

5. Social Security Number

215-18-0691

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

87

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
June 23, 1911

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Havre de Grace

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

428 Market Street

10f. Zip Code

21078

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
Twelve Years

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Ticket Agent

16b. Kind of Business/Industry

Amtrak Railroad  
Chester, Pennsylvania

17. Father's Name (First, Middle, Last)

Winfield Scott

18. Mother's Name (First, Middle, Maiden Summa)

Julia Veronica McLhinney

19a. Informant's Name/Relationship (Type, Print)

Stanley N. Craig (nephew)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7004 Emerson Street, Hyattsville, Maryland 20784

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Asbury Cemetery

Date

12/30/98

20c. Location - City or Town, State

Port Deposit, Maryland

21. Signature of Funeral Service Licensee

Lee A. Patterson, Sr.

22. Name and Address of Facility

Lee A. Patterson & Son Funeral Home  
Perryville, Maryland 21903-018823a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. MYOCARDIAL INFARCTION

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

3 DAYS

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

YEARS

c. ATRIAL FIBRILLATION

Due to (or as a consequence of):

YEARS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

James M. L...

29c. License number

H44463

29d. Date signed (Month, Day, Year)

DECEMBER 28, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

James S. Ley 412 SUBURBAN DRIVE NEWARK, DELAWARE 19711

State  
Registrar

31. Date filed (Month, Day, Year)

DEC 30 1998

32. Registrar's Signature

Denise B. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
permit.

Division of Vital Records, P.O. Box 68760,





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41425

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MARY MAGGIE CURTIS

2. Date of Death

December 26, 1998

3. Time of Death

1802

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

Funeral  
Director

5. Social Security Number

216-14-9539

6. Sex

1 ☐ M 2 ☐ F

7. Age (In yrs. last birthday)

71

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

February 19, 1927

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State

MD

10b. County

Wicomico

10c. City, Town or Location

Salisbury

10d. Inside City Limits

1 ☐ Yes 2 ☐ No

10e. Street and Number

741 S. Division St

10f. Zip Code

21801

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Domestic

16b. Kind of Business/Industry

Self-Emp.

17. Father's Name (First, Middle, Last)

NOAH ELLIS

18. Mother's Name (First, Middle, Maiden Surname)

NORWOOD CURTIS

19a. Informant's Name/Relationship (Type, Print)

MARY JEAN EVERETT DAYNE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

741 S. Division St Salisbury MD 21801

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GREEN ACRES MEM

Date

12/30/98

20c. Location - City or Town, State

Salisbury MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

BENNETT SMITH 1914  
Ocean Gate Hwy Salisbury MD

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Cardiac Arrest / CORONARY ARTERY DISEASE

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

024872

29d. Date signed (Month, Day, Year)

December 26, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

360 RIVERSIDE DR A704 SALISBURY MD 21801

31. Date filed (Month, Day, Year)

DEC 30 1998

32. Registrar's Signature

State Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41426

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) <b>EDITH JEAN DUNSTEN</b>				2. Date of Death Month <b>December</b> Day <b>29</b> Year <b>1998</b>		3. Time of Death <b>0804</b>	
4a. Facility Name (If not institution, give street and number) <b>PENINSULA REGIONAL MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>SALISBURY</b>		4c. County of Death <b>WICOMICO</b>	
5. Social Security Number <b>203-20-4237</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (in yrs. last birthday) <b>83</b>		8. Date of Birth (Month, Day, Year) <b>August 15, 1915</b>	
9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>		10a. State <b>Maryland</b>		10b. County <b>Wicomico</b>		10c. City, Town or Location <b>Salisbury</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>1514 Riverside Dr., Apt. C121</b>		10f. Zip Code <b>21801</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Teacher</b>		16b. Kind of Business/Industry <b>Education</b>		17. Father's Name (First, Middle, Last) <b>Burd Allen Eltringham</b>	
18. Mother's Name (First, Middle, Maiden Surname) <b>Lillian Almeda Resh</b>		19a. Informant's Name/Relationship (Type, Print) <b>George G. Dunsten/Son</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>408 Cobblers Green, Salisbury, MD 21801</b>		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	
20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Salisbury Crematory</b>		20c. Date <b>12/30/98</b>		20d. Location - City or Town, State <b>Salisbury, MD</b>		21. Signature of Funeral Service Licensee <b>[Signature]</b>	
22. Name and Address of Facility <b>Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804</b>		23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  e. <b>ACUTE STROKE OR PULMONARY EMBOLUS</b> Due to (or as a consequence of): b. <b>ASCVD</b> Due to (or as a consequence of): c. <b>RECENT AORTIC VALVE REPLACEMENT</b> Due to (or as a consequence of): d. <b>WITH CABG X1</b>		Approximate Interval Between Onset and Death <b>YRS</b> <b>6 DAYS</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
24a. Were an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) <b>12/29/98</b>		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
29b. Signature and title of certifier <b>[Signature]</b>		29c. License number <b>020912</b>		29d. Date signed (Month, Day, Year) <b>12/29/98</b>		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Dennis J. Chodnicki M.D. 400 EASTERN SHORE DR. SALISBURY, MD 21804</b>	
31. Date filed (Month, Day, Year) <b>DEC 31 1998</b>		32. Registrar's Signature <b>[Signature]</b>		33. State Registrar		34. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

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Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41427

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Ethel M. Ferguson

2. Date of Death

December 28, 1998

3. Time of Death

8:45 PM

4a. Facility Name (If not institution, give street and number)

Laurelwood Nursing Home

4b. City, Town, or Location of Death

Elkton

4c. County of Death

Cecil

Funeral  
Director

5. Social Security Number

197-12-1284

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

74 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Aug. 27, 1924

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Pennsylvania

10b. County

Chester

10c. City, Town or Location

Landenburg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

154 Strickersville Rd.

10f. Zip Code

19350

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
8

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Family Farm

17. Father's Name (First, Middle, Last)

Enos B. Ferguson

18. Mother's Name (First, Middle, Maiden Surname)

Jeanette Lee

19a. Informant's Name/Relationship (Type, Print)

James Ferguson/Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

154 Strickersville Rd. Landenburg, PA 19350

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

New London Pres. Cemetery 1-2-99

Date

20c. Location - City or Town, State

New London, PA

21. Signature of Funeral Service Licensee

Richard L. Goodie

22. Name and Address of Facility

R. T. Foard Funeral Home, P. A.  
111 S. Queen St. Rising Sun, MD 21911

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Metastatic lung cancer

Approximate Interval Between Onset and Death

7 1/2 years

Due to (or as a consequence of):

b. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Obstructive hydrocephalus secondary to brain mets

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

L. L. F. J. C.

29c. License number

027339

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

C. P. A. F. M. C. 101 E. Wheel Road Bel Air MD 21011

State  
Registrar

31. Date filed (Month, Day, Year)

DEC 30 1998

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 21 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

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Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41428

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Mildred M. Feliciani</b>				2. Date of Death Month Day Year <b>December 30, 1998</b>		3. Time of Death <b>0630</b>	
	4a. Facility Name (If not institution, give street and number) <b>123 Whitehall Road</b>				4b. City, Town, or Location of Death <b>Elkton</b>		4c. County of Death <b>Cecil</b>	
Funeral Director	5. Social Security Number <b>159-26-6804</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>74</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>November 6, 1924</b>	
	9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>		10. Usual Residence of Decedent		10a. State <b>Maryland</b>		10b. County <b>Cecil</b>	
10c. City, Town or Location <b>Elkton</b>		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number <b>123 Whitehall Road</b>		10f. Zip Code <b>21921</b>		
10g. Citizen of What Country? <b>United States</b>		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>in her own home</b>		
17. Father's Name (First, Middle, Last) <b>Pietro Alosi</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Giacomina Cavalierro</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Marsha Feliciani/ Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1065 Kawaiahao Street, Honolulu, Hawaii 96814</b>				
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>R.A. Ferris and Company</b>		Date <b>December 30, 1998</b>		20c. Location - City or Town, State <b>West Chester, Pennsylvania</b>		
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <b>Hicks Home for Funerals, P.A. 103 West Stockton Street, Elkton, Maryland 21921</b>				
23. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Acute Myelocytic Leukemia</b> <b>Chronic Cancer</b>								
24. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Acute Myelocytic Leukemia</b> <b>Chronic Cancer</b>								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how Injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		28g. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <b>Yogish A. Patel</b>		29c. License number <b>D18940</b>		29d. Date signed (Month, Day, Year) <b>12-30-98</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Yogish Patel, M.D., 111 W. High St, #104, Elkton, MD 21921</b>		
31. Date filed (Month, Day, Year) <b>DEC 30 1998</b>		32. Registrar's Signature <i>[Signature]</i>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760, CVT

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

110

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41429

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JOHN BENTON FOWLER</b>				2. Date of Death Month Day Year <b>December 25, 1998</b>		3. Time of Death <b>11:50 PM</b>	
	4a. Facility Name (If not Institution, give street and number) <b>34291 Old Ocean City Rd</b>				4b. City, Town, or Location of Death <b>Pittsville</b>		4c. County of Death <b>Wicomico</b>	
Funeral Director	5. Social Security Number <b>579-10-0548</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>77</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>May 9, 1921</b>	
	9. Birthplace (State or Foreign Country) <b>Virginia</b>		10a. State <b>Maryland</b>		10b. County <b>Wicomico</b>		10c. City, Town or Location <b>Pittsville</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>34291 Old Ocean City Rd</b>		10f. Zip Code <b>21850</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Carpenter</b>		16b. Kind of Business/Industry <b>Carpentry</b>				
17. Father's Name (First, Middle, Last) <b>John Joseph Fowler</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Helen Virginia Shenk</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Eva Grace Fowler/Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>34291 Old Ocean City Rd., Pittsville, MD 21850</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Ft. Lincoln Cemetery</b>		20c. Location - City or Town, State <b>Washington, DC</b>		20d. Date <b>12/29/98</b>		
21. Signature of Funeral Service Licensee <i>David H. Thompson</i> MO1051				22. Name and Address of Facility <b>Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  e. <b>Metastatic Carcinoma, Unknown Primary</b> Due to (or as a consequence of): <b>Origin</b>  f. Due to (or as a consequence of):  g. Due to (or as a consequence of):  h. Due to (or as a consequence of):								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>James E. Martin</i> M.D.		29c. License number <b>030690</b>		29d. Date signed (Month, Day, Year) <b>Dec. 29, 1998</b>				
30. Name and address of person who completed causa of death (Item 23e) (Type, Print) <b>James E. Martin, M.D., 145 E. Carroll St., Salisbury, MD.</b>								
31. Date filed (Month, Day, Year) <b>DEC 30 1998</b>		32. Registrar's Signature <i>James E. Martin</i>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41430

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ELIZABETH FOREMAN</b>				2. Date of Death Month Day Year <b>DECEMBER 25 1998</b>		3. Time of Death <b>6:40 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Berlin Nursing &amp; Rehabilitation Center</b>				4b. City, Town, or Location of Death <b>Berlin</b>		4c. County of Death <b>Worcester</b>	
Funeral Director	5. Social Security Number <b>213-16-8392</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>84</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Nov 28, 1914</b>	
	9. Birthplace (State or Foreign Country) <b>MD</b>		10. Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>Worcester</b> 10c. City, Town or Location <b>Berlin</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number <b>8526 Ironshire Station Rd.</b>		10f. Zip Code <b>21811</b>		10g. Citizen of What Country? <b>U.S.</b>				
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7th</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Presser</b>		16b. Kind of Business/Industry <b>Laundry/Cleaners</b>				
17. Father's Name (First, Middle, Last) <b>Elijah Purnell</b>				18. Mother's Name (First, Middle, Maiden Summa) <b>Eliza Selby</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Edna Tindley/daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8837 Ironshire Station Rd., Berlin, MD 21811</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Calvary UMC Cemetery</b>		20c. Date <b>12/31/98</b>		20d. Location - City or Town, State <b>Berlin, MD</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Lewis N. Watson Funeral Home 1618 West Rd., Salisbury, MD 21801</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Arteriosclerotic Cardiovascular Disease 1 yr</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 				29c. License number <b>D29505</b>		29d. Date signed (Month, Day, Year) <b>12-25-98</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>GREGORIO M. BELLOSO, M.D., 5302 CHINABERRY DR., SALISBURY, MD, 21801</b>								
31. Date filed (Month, Day, Year) <b>DEC 30 1998</b>				32. Registrar's Signature 				

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Georgia Griffin

2. Date of Death

Dec. 24 1998

3. Time of Death

1506

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

Funeral  
Director

5. Social Security Number

251-54-7614

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

April 17, 1914

9. Birthplace (State or Foreign Country)

SC

Usual Residence of Decedent

10a. State

MD

10b. County

Worcester

10c. City, Town or Location

Berlin

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

209 Branch Street

10f. Zip Code

21811

10g. Citizen of What Country?

U.S.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) College (1-4or 5+)  
3rd

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Maid

16b. Kind of Business/Industry

Private Families

17. Father's Name (First, Middle, Last)

George Washington Greene, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Hattie Greene

19a. Informant's Name/Relationship (Type, Print)

Annie Sumter/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

209 Branch St., Berlin, MD 21811

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

New Bethel UMC Cemetery

Date

1/2/99

20c. Location - City or Town, State

Berlin, MD 21811

21. Signature of Funeral Service Licensee

*[Signature]*

22. Name and Address of Facility

Lewis N. Watson Funeral Home  
1618 West Rd., Salisbury, MD 21801

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sudden death

Due to (or as a consequence of):

Cardiovascular arrest

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dehydration  
O. white matter

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☒ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*[Signature]*

29c. License number

025674

29d. Date signed (Month, Day, Year)

12/26/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W. A. Cocks, Jr., 100 Power St., Salisbury, MD 21801

31. Date filed (Month, Day, Year)

DEC 30 1998

32. Registrar's Signature

*[Signature]*

State  
Registrar

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 25a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Georgia Griffin  
251-54-7614



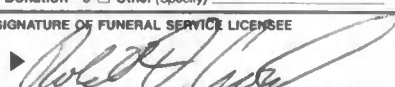



98 41432

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Linda Ellen Higgins</b>				2. DATE OF DEATH MONTH <b>December</b> DAY <b>30</b> YEAR <b>1998</b>				3. TIME OF DEATH <b>00:30 M</b>							
4. SOCIAL SECURITY NUMBER <b>137-42-4075</b>		5. SEX <b>1</b> <input type="checkbox"/> M <b>2</b> <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>50</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>July 19, 1948</b>		8. BIRTHPLACE (State or Foreign Country) <b>New Jersey</b>								
9a. FACILITY NAME (If not institution, give street and number) <b>559 Marley Road</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Elkton</b>				9c. COUNTY OF DEATH <b>Cecil</b>							
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Cecil</b>		10c. CITY, TOWN OR LOCATION <b>Elkton</b>		10d. INSIDE CITY LIMITS? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER <b>559 Marley Road</b>				10f. ZIP CODE <b>21921</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>									
11. MARITAL STATUS <b>1</b> <input checked="" type="checkbox"/> Never Married <b>2</b> <input type="checkbox"/> Married <b>3</b> <input type="checkbox"/> Widowed <b>4</b> <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>									
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Accounting Department Vice President</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Banking</b>											
17. FATHER'S NAME (First, Middle, Last) <b>Theodore John Higgins</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Carol Meaney</b>											
19a. INFORMANT'S NAME (Type/Print) <b>Joy Kalmbach / Companion</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>559 Marley Road, Elkton, MD 21921</b>											
20a. METHOD OF DISPOSITION <b>1</b> <input type="checkbox"/> Burial <b>2</b> <input checked="" type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State <b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>R.A. Ferris Crematory</b>		DATE <b>01/04/1999</b>		20c. LOCATION — City or Town, State <b>West Chester Pennsylvania</b>									
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Crouch Funeral Home 127 South Main Street, North East MD 21901</b>											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Breast Cancer</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b> b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death <b>6 years</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>															
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1</b> <input type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA OTHER: <b>4</b> <input checked="" type="checkbox"/> Nursing Home <b>5</b> <input checked="" type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify)													
27. MANNER OF DEATH <b>1</b> <input checked="" type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending Investigation <b>2</b> <input type="checkbox"/> Accident <b>3</b> <input type="checkbox"/> Suicide <b>4</b> <input type="checkbox"/> Homicide <b>6</b> <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED							
29a. CERTIFIER (Check only one) <b>1</b> <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>H. Farkas, MD</b>										29c. LICENSE NUMBER <b>D15714</b>		29d. DATE SIGNED (Month, Day, Year) <b>Dec. 30, 1998</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>H. Farkas, MD VNA/Northern Chesapeake Hospice, Elkton, MD</b>															
31. DATE FILED (Month, Day, Year) <b>DEC 31 1998</b>				32. REGISTRAR'S SIGNATURE 											

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

EDWARD THOMAS HUGHES

2. Date of Death

December 27 1998

3. Time of Death

1206

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

Funeral  
Director

5. Social Security Number

214 10 9437

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

JULY 18, 1917

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

WORCESTER

10c. City, Town or Location

POCOMOKE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1829 BUCK HARBOR RD.

10f. Zip Code

21851

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: ARMY

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

REPAIRMAN

16b. Kind of Business/Industry

SELF-EMPLOYED

17. Father's Name (First, Middle, Last)

CHARLES V. HUGHES

18. Mother's Name (First, Middle, Maiden Surname)

MARY A. FITCHETT

19a. Informant's Name/Relationship (Type, Print)

LORIE A. DEAN - GRANDDAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

112 WILLIAMS AVE. FRUITLAND, MD 21826

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

NELSON CEMETERY

Date

12-30-98

20c. Location - City or Town, State

NEW CHURCH, VA.

21. Signature of Funeral Service Licensee

B. Keith Phyllis CFSP

22. Name and Address of Facility

705 E. MAIN ST.  
BOUNDS FUNERAL HOME, INC. SALISBURY, MD 21804

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. cerebrovascular acc. but

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

chronic atrial fibrillation  
coronary atherosclerosis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J. A. Cochran

29c. License number

D25174

29d. Date signed (Month, Day, Year)

12/30/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. A. Cochran, MD 100 Power Rd, Salisbury, MD 21804

31. Date filed (Month, Day, Year)

DEC 30 1998

32. Registrar's Signature

Benita B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

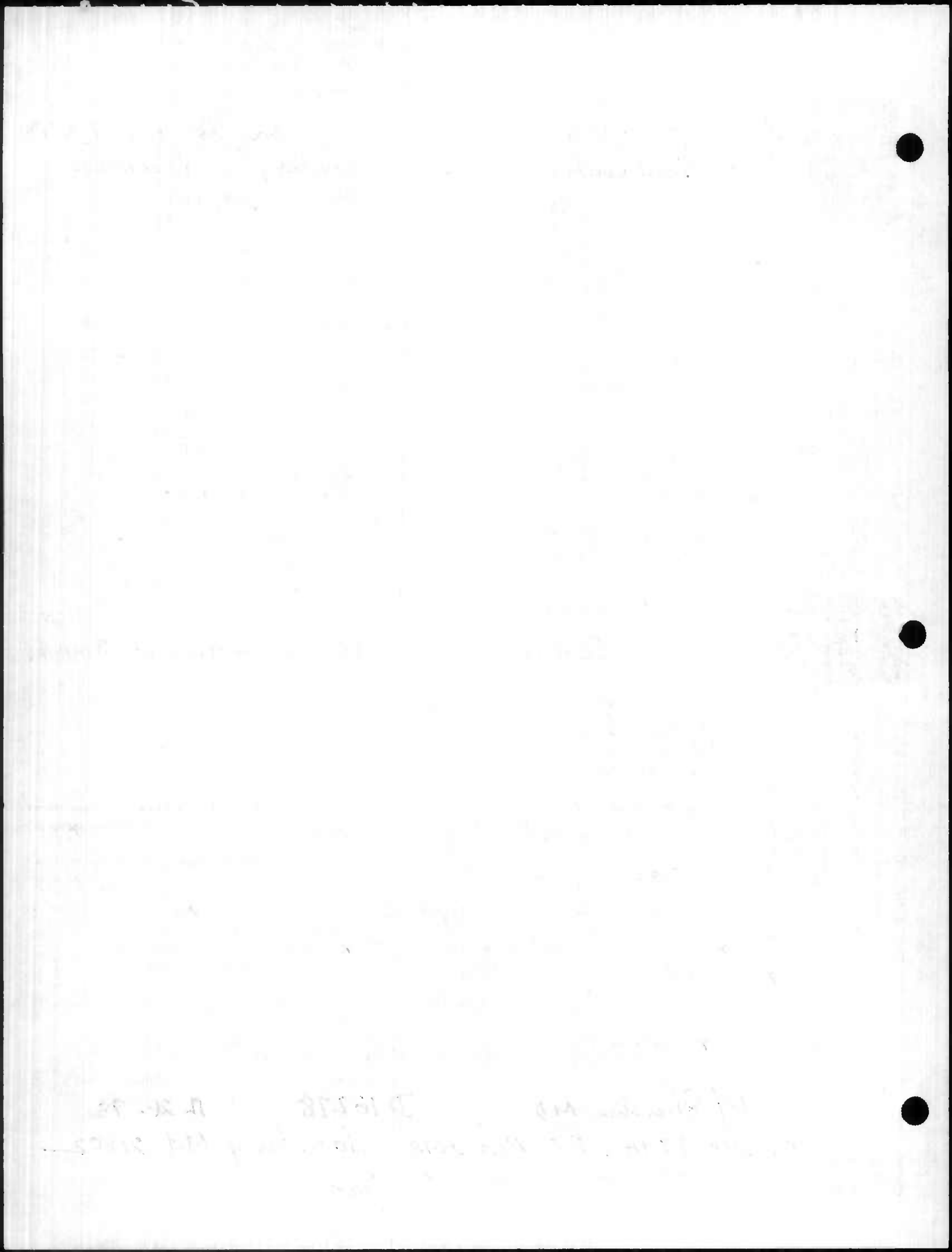
Reg. No.

98 41434

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>John F. Hawks</b>				2. Date of Death Month <b>Dec</b> Day <b>25</b> Year <b>1998</b>		3. Time of Death <b>9.25 PM</b>	
	4a. Facility Name (If not Institution, give street and number) <b>Deer's Head Center</b>				4b. City, Town, or Location of Death <b>Salisbury</b>		4c. County of Death <b>WICOMICO</b>	
Funeral Director	5. Social Security Number <b>257-38-7976</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>71</b>		8. Date of Birth (Month, Day, Year) <b>JAN. 23, 1927</b>	
	Usual Residence of Decedent		10e. State <b>MD.</b>		10b. County <b>WICOMICO</b>		10c. City, Town or Location <b>SALISBURY</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>351 DEER HEAD ROAD</b>		10f. Zip Code <b>21801</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>AFRO-AMERICAN</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b>		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>LABORER</b>		17. Kind of Business/Industry <b>TEXTILE WORKER</b>			
	17. Father's Name (First, Middle, Last) <b>WILLIE HAWKS</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>BULAH LITTLE</b>		19a. Informant's Name/Relationship (Type, Print) <b>REV. ADELL HAWKS</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>771 NORWOOD STREET, GAINESVILLE, GA.</b>	
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>BLACK SPRING CHURCH</b>		20c. Date <b>12-30</b>		20d. Location - City or Town, State <b>COMMERCE GA. 30529</b>	
	21. Signature of Funeral Service Licensee <b>Laith B. Jolley</b>		22. Name and Address of Facility <b>JOLLEY MEMORIAL CHAPEL</b> <b>1213 jersey ROAD, SALISBURY, MARYLAND 21801</b>		23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>e. Cerebrovascular accident - recurrent 5 months</b>  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>a. {</b> <b>b. {</b> <b>c. {</b> <b>d. {</b>		Approximate Interval Between Onset and Death	
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24f. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	
	28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>M. Shrestha MD</b>		29c. License number <b>D16278</b>		29d. Date signed (Month, Day, Year) <b>12.26.98</b>	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>M. SHRESTHA, P.O. Box 2018, Salisbury Md 21802</b>		31. Date filed (Month, Day, Year) <b>DEC 31 1998</b>		32. Registrar's Signature <b>Beverly B. Sparks</b>				

Baltimore, Maryland 21215-0020

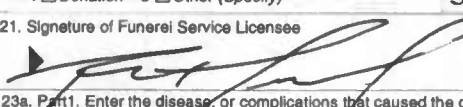
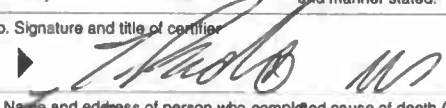

Division of Vital Records, P.O. Box 68760,





**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

Reg. No.

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <i>Wanda R. Iracki</i>						2. Date of Death Month <i>December</i> Day <i>30</i> Year <i>1998</i>		3. Time of Death <i>10:40 PM</i>	
	4a. Facility Name (If not institution, give street and number) <i>Calvert Manor Healthcare Center</i>						4b. City, Town, or Location of Death <i>Rising Sun</i>		4c. County of Death <i>Cecil</i>	
<b>Funeral Director</b>	5. Social Security Number <i>075-12-2971</i>		8. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>77</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>Aug. 24, 1921</i>		9. Birthplace (State or Foreign Country) <i>Pennsylvania</i>	
	Usual Residence of Decedent									
10a. State <i>PA</i>		10b. County <i>Luzerne</i>		10c. City, Town or Location <i>Nanticoke</i>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <i>248 W. Main St.</i>				10f. Zip Code <i>18634</i>		10g. Citizen of What Country? <i>USA</i>				
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <i>White</i>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Housewife</i>			16b. Kind of Business/Industry <i>Home</i>			
17. Father's Name (First, Middle, Last) <i>Stanley Gryniewicki</i>						18. Mother's Name (First, Middle, Maiden Surname) <i>Regina Baurys</i>				
19a. Informant's Name/Relationship (Type, Print) <i>Dr. Edwin Iracki/Son</i>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>11 Josh's Way Landenberg, PA 19350</i>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <i>St. Mary's Cemetery</i>			Date <i>1-4-99</i>		20c. Location - City or Town, State <i>Wilkes-Barre, PA</i>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <i>R. T. Foard Funeral Home, P. A. 111 S. Queen St., Rising Sun, MD 21911</i>						
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <i>Stroke MI</i> Due to (or as a consequence of):  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.										Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>- DEMENTIA - ASCVD.</i> <i>- RENAL FAILURE - CHRONIC URINARY INFECTIONS</i> <i>- ELECTROLYTE IMBALANCE</i>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier 				29c. License number <i>D42800</i>		29d. Date signed (Month, Day, Year) <i>12/31/98</i>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>319 S. UNION AVENUE HAVRE DE GRACE MD 21078, T. Brando MD</i>										
31. Date filed (Month, Day, Year) <i>DEC 31 1998</i>			32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

Reg. No.

98 41436

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>Tawes McNamara Insley</b>				2. Date of Death Month <b>December</b> Day <b>27</b> , Year <b>1998</b>		3. Time of Death <b>1:45 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Chesapeake Woods Center</b>				4b. City, Town, or Location of Death <b>Cambridge</b>		4c. County of Death <b>Dorchester</b>	
<b>Funeral Director</b>	5. Social Security Number <b>220-03-6577</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>86</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>April 26, 1912</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>Dorchester</b>		10c. City, Town or Location <b>Cambridge</b>	
<b>To Be Completed by Funeral Director</b>	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>525 Glenburn Avenue</b>		10f. Zip Code <b>21613</b>		10g. Citizen of What Country? <b>US</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>42 45</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>2</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Farmer</b>		16b. Kind of Business/Industry <b>Agriculture</b>			
	17. Father's Name (First, Middle, Last) <b>John Herman Insley</b>				18. Mother's Name (First, Middle, Maiden Summa) <b>Blanche McNamara</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Mary I. Montroy Sister</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>525 Glenburn Avenue Cambridge, Maryland 21613</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Dorchester Memorial Park</b>		20c. Date <b>1/3/99</b>		20d. Location - City or Town, State <b>Cambridge, Maryland</b>	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Thomas Funeral Home, P.A. 700 Locust Street Cambridge, Maryland 21613</b>			
	23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <div style="display: flex; justify-content: space-between;"> <div style="width: 70%;"> <p>a. <b>Cardiopulmonary arrest</b></p> <p>b. <b>S/P multiple CVA</b></p> <p>c. <b>Diabetes mellitus</b></p> <p>d. <b>Hypertension</b></p> </div> <div style="width: 25%; text-align: center;"> <p>Due to (or as a consequence of):</p> <p>Due to (or as a consequence of):</p> <p>Due to (or as a consequence of):</p> <p>Due to (or as a consequence of):</p> </div> <div style="width: 5%;"> <p>Approximate Interval Between Onset and Death</p> <p><b>min.</b></p> <p><b>years.</b></p> <p><b>years.</b></p> <p><b>years.</b></p> </div> </div>							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
<b>Medical Certification: To Be Completed by Physician/Medical Examiner</b>	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					
	28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
	29b. Signature and title of certifier 		29c. License number <b>D50987</b>		29d. Date signed (Month, Day, Year) <b>12/30/98</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Ahmed Nawaz 105 Aurora street Cambridge MD 21613</b>								
<b>State Registrar</b>	31. Date filed (Month, Day, Year) <b>DEC 30 1998</b>		32. Registrar's Signature 					

Baltimore, Maryland 21215-0020 Jdb

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41437

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>NANCY ROSCOE JONES</b>				2. Date of Death Month <b>December</b> Day <b>29</b> Year <b>1998</b>				3. Time of Death <b>8:14pm</b>	
	4a. Facility Name (If not institution, give street and number) <b>Memorial Hospital</b>				4b. City, Town, or Location of Death <b>Easton</b>				4c. County of Death <b>Talbot</b>	
Funeral Director	5. Social Security Number <b>215-28-1170</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>69</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Oct 28 1929</b>		9. Birthplace (State or Foreign Country) <b>Illinois</b>	
	Usual Residence of Decedent									
10a. State <b>MD</b>		10b. County <b>Queen Anne's</b>		10c. City, Town or Location <b>Centreville</b>				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10e. Street and Number <b>106 Corsica St.</b>				10f. Zip Code <b>21617</b>				10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Secretary</b>				16b. Kind of Business/Industry <b>Queen Anne's Co. Assessment Office</b>		
17. Father's Name (First, Middle, Last) <b>Robert R. Roscoe</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mabel Domier</b>						
19a. Informant's Name/Relationship (Type, Print) <b>Roger C. Jones (husband)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>106 Corsica St. Centreville, MD. 21617</b>						
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Capitol Crematory</b>		20c. Date <b>12/31/98</b>		20d. Location - City or Town, State <b>Dover, DE.</b>				
21. Signature of Funeral Service Licensee  <b>M00510</b>				22. Name and Address of Facility <b>Galena Funeral Home of Stephen Schaeck</b> <b>Box 235 Galena, MD. 21635</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  e. <b>Acute Cardiorespiratory Arrest</b> Due to (or as a consequence of):  b. <b>Acute Myocardial Infarction</b> Due to (or as a consequence of):  c. _____ Due to (or as a consequence of):  d. _____ Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death  <b>30 min.</b>  <b>8 hours</b>		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <b>Asthma</b>								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 				29c. License number <b>H 42587</b>		29d. Date signed (Month, Day, Year) <b>Dec. 30, 1998</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Russell A. Schilling D.O. 2540 Centreville Rd. Centreville MD. 21617</b>										
31. Date filed (Month, Day, Year) <b>DEC 31 1998</b>		32. Registrar's Signature 								

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41438

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ELVA ALICE LARMORE</b>				2. Date of Death Month <b>December</b> Day <b>27</b> Year <b>1998</b>		3. Time of Death <b>4:23 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>Wicomico Nursing Home</b>				4b. City, Town, or Location of Death <b>Salisbury, MD</b>		4c. County of Death <b>Wicomico</b>		
Funeral Director	5. Social Security Number <b>217-24-9645</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>92</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>May 13, 1906</b>		
	9. Birthplace (State or Foreign Country) <b>Minnesota</b>		10a. State <b>Maryland</b>		10b. County <b>Wicomico</b>		10c. City, Town or Location <b>Salisbury</b>		
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>900 Booth St</b>		10f. Zip Code <b>21801</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4or 5+) <b>-</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Buyer</b>		16b. Kind of Business/Industry <b>Woodward &amp; Lothrop</b>					
17. Father's Name (First, Middle, Last) <b>Niles Frederick Larson</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Lottie Grace Watson</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Naomi L. Weitzel/Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>39 Chuckanut Dr., Oakland, NJ 07436</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Wicomico Memorial Park</b>		Date <b>12/30/98</b>		20c. Location - City or Town, State <b>Salisbury, MD</b>			
21. Signature of Funeral Service Licensee <i>David H. Thompson</i> <b>MO1051</b>		22. Name and Address of Facility <b>Holloway Funeral Home Professional Association</b> <b>501 Snow Hill Rd., Salisbury, MD 21804</b>							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. <i>Arteriosclerotic Cardiovascular Disease</i> 5 yrs</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. _____ Due to (or as a consequence of):</b> <b>c. _____ Due to (or as a consequence of):</b> <b>d. _____</b>								Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b><i>Bilateral Metastatic Lung Cancer</i></b> <b><i>Senile Dementia; Hypertension</i></b> <b><i>Anemia</i></b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Gregoria M. Belloso MD</i>		29c. License number <b>D 29505</b>		29d. Date signed (Month, Day, Year) <b>12-27-98</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Gregoria M. Belloso, MD - 5302 Chinaberry Dr., Salis., MD 21801</b>		31. Date filed (Month, Day, Year) <b>DEC 30 1998</b>		32. Registrar's Signature <i>Beverly S Sparks</i>					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

ELVA A. LARMORE





**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

Reg. No.

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>CHARLES, HERMAN, MOORE</b>					2. Date of Death Month <b>DECEMBER</b> Day <b>29</b> Year <b>1998</b>		3. Time of Death <b>1355</b>																
	4a. Facility Name (If not institution, give street and number) <b>Union Hospital</b>					4b. City, Town, or Location of Death <b>Elkton</b>		4c. County of Death <b>Cecil</b>																
<b>Funeral Director</b>	5. Social Security Number <b>722-16-3594</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>74</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>10-01-1924</b>		9. Birthplace (State or Foreign Country) <b>Virginia</b>															
	Usual Residence of Decedent																							
10a. State <b>DE</b>		10b. County <b>New Castle</b>		10c. City, Town or Location <b>Newark</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																
10e. Street and Number <b>502 Scotland Drive</b>					10f. Zip Code <b>19702</b>		10g. Citizen of What Country? <b>U.S.A.</b>																	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>8/17/42-10/10/42</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>																	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Self-employed</b>			16b. Kind of Business/Industry <b>Painting</b>																
17. Father's Name (First, Middle, Last) <b>John M. Moore</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Ann M. Wilson</b>																			
19a. Informant's Name/Relationship (Type, Print) <b>Karen Hill/ Granddaughter</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>244 Cheyenne Drive, Bear, DE 19701</b>																			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)					20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Delaware Veterans Me. Cem</b>		20c. Location - City or Town, State <b>Bear, DE</b>																	
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility <b>Beeson Memorial Services 2053 Pulaski Hwy., Newark, DE 19702</b>																			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																								
<table border="0" style="width:100%;"> <tr> <td style="width:30%;">Immediate Cause (Final disease or condition resulting in death)</td> <td style="width:50%;"><b>e. RENAL CELL CANCER</b></td> <td style="width:20%;">Approximate Interval Between Onset and Death <b>3 years</b></td> </tr> <tr> <td colspan="3">Due to (or as a consequence of):</td> </tr> <tr> <td rowspan="4" style="vertical-align: middle; font-size: 3em;">{</td> <td>b.</td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>c.</td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td colspan="2">Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death)	<b>e. RENAL CELL CANCER</b>	Approximate Interval Between Onset and Death <b>3 years</b>	Due to (or as a consequence of):			{	b.	Due to (or as a consequence of):	c.	Due to (or as a consequence of):	d.	Due to (or as a consequence of):	Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	
Immediate Cause (Final disease or condition resulting in death)	<b>e. RENAL CELL CANCER</b>	Approximate Interval Between Onset and Death <b>3 years</b>																						
Due to (or as a consequence of):																								
{	b.	Due to (or as a consequence of):																						
	c.	Due to (or as a consequence of):																						
	d.	Due to (or as a consequence of):																						
	Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last																							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown																								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined					28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No															
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28d. Describe how injury occurred																			
28f. Location (Street and Number or Rural Route Number, City or Town, State)																								
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																								
29b. Signature and title of certifier 					29c. License number <b>D0053034</b>		29d. Date signed (Month, Day, Year) <b>12/31/98</b>																	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>MARC SCHEINER M.D. 223 W MAIN ST ELKTON MD 21921</b>																								
31. Date filed (Month, Day, Year) <b>DEC 31 1998</b>					32. Registrar's Signature 																			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Rosie Ella Mills

2. Date of Death

Month Day Year  
December 30, 1998

3. Time of Death

3:30 AM

4a. Facility Name (If not institution, give street and number)

Mallard Bay Center

4b. City, Town, or Location of Death

Cambridge

4c. County of Death

Dorchester

Funeral  
Director

5. Social Security Number

220-01-8174

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
May 26, 1909

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Dorchester

10c. City, Town or Location

Cambridge

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

404 Cemetery Avenue

10f. Zip Code

21613

10g. Citizen of What Country?

US

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Crab Picker

16b. Kind of Business/Industry

Seafood

17. Father's Name (First, Middle, Last)

Charles Abbott

18. Mother's Name (First, Middle, Maiden Surname)

Mary Jane Willey

19a. Informant's Name/Relationship (Type, Print)

Lillie T. Warfield Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5513 Second Street Cambridge, Maryland 21613

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Sandy Island Cemetery

Date

1/3/99

20c. Location - City or Town, State

Robbins, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Thomas Funeral Home, P.A.

700 Locust Street Cambridge, Maryland 21613

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

S/P 4 temporo parietal stroke

Due to (or as a consequence of):

b.

legally blind

Due to (or as a consequence of):

c.

Hypertension

Due to (or as a consequence of):

d.

Aspiration pneumonia

Approximate Interval Between Onset and Death

Weeks

Years

Years

Weeks

Sequently list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Electrolyte imbalance

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D50987

29d. Date signed (Month, Day, Year)

1/31/98

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Ahmed Nawaz MD 105 Aurora Street Cambridge, Maryland 21613

31. Date filed (Month, Day, Year)

JAN 04 1999

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41441

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Willie Meekins

2. Date of Death

Month Day Year  
12 27 98

3. Time of Death

8.30pm

4a. Facility Name (If not institution, give street and number)

Dorchester General Hospital

4b. City, Town, or Location of Death

Cambridge

4c. County of Death

Dorchester

Funeral  
Director

5. Social Security Number

217-16-9245

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

88

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Sept. 22, 1910

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Dorchester

10c. City, Town or Location

Fishing Creek

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1220 Horse Point Road

10f. Zip Code

21634

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
3

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Waterman

16b. Kind of Business/Industry

Shellfish

17. Father's Name (First, Middle, Last)

Alfred Meekins

18. Mother's Name (First, Middle, Maiden Surname)

Octavia Parks

19a. Informant's Name/Relationship (Type, Print)

Calvin W. Meekins/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Rt. 1, Box 214 C, Laurel, DE 19956

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MD Veterans Cemetery

Date

12-31

20c. Location - City or Town, State

Hurlock, MD

21. Signature of Funeral Service Licensee

Curran-Bromwell

22. Name and Address of Facility

Curran-Bromwell Funeral Home, P.A.  
308 High St., Cambridge, MD 21613

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Due to (or as a consequence of):

Pneumonia

Approximate Interval Between Onset and Death

2 weeks

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

UTI, Organic Brain Syndrome

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

E. Tanman

29c. License number

214349

29d. Date signed (Month, Day, Year)

12-28-98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Eyup Tanman, M.D., 15 Franklin Street, Cambridge, Md. 21613

31. Date filed (Month, Day, Year)

DEC 30 1998

32. Registrar's Signature

B. Sparks

State  
RegistrarBaltimore, Maryland 21215-0020 fdb  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41442

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ALFRED RICHARD MARYANOV

2. Date of Death

December 29 1998

3. Time of Death

0500

4a. Facility Name (If not Institution, give street and number)

300 Somerset Ave.

4b. City, Town, or Location of Death

Cambridge

4c. County of Death

Dorchester

Funeral  
Director

5. Social Security Number

220-10-8009

6. Sex

X M 2 F

7. Age (In yrs. last birthday)

85

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

Dec 2, 1913

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Dorchester

10c. City, Town or Location

Cambridge

10d. Inside City Limits

X Yes 2 No

10e. Street and Number

300 Somerset Avenue

10f. Zip Code

21613

10g. Citizen of What Country?

US

11. Marital Status

1 Never Married 2 X Married  
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No  
If Yes, Give Year or Dates: 42-46

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes X No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12College (1-4 or 5+)  
5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Medical Doctor

16b. Kind of Business/Industry

Healthcare

17. Father's Name (First, Middle, Last)

Harry Maryanov

18. Mother's Name (First, Middle, Maiden Surname)

Minnie Meline

19a. Informant's Name/Relationship (Type, Print)

Mary D. Maryanov Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

300 Somerset Avenue Cambridge, Maryland 21613

20a. Method of Disposition

1 X Burial 2 Cremation 3 Removal from State  
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Old Trinity Churchyard

Date

12/31/98

20c. Location - City or Town, State

Church Creek, MD

21. Signature of Funeral Service Licensee

Kenneth R. Thomas Jr.

22. Name and Address of Facility

Thomas Funeral Home, P.A.  
700 Locust Street Cambridge, Maryland 21613

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ARTERIO-SCLEROTIC CARDIO VASCULAR DISEASE  
Due to (or as a consequence of):  
4 YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Aneurysm of Ascending Aorta

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 X No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 X No

25. Was case referred to medical examiner?

1 Yes 2 X No

26. Place of Death (Check only one)

Hospital: 1 Inpatient 2 X ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify)

27. Manner of Death

1 Natural 5 Pending investigation  
2 Accident 6 Could not be determined  
3 Suicide 4 Homicide

28a. Date of injury (Month, Day Year)

28b. Time of injury

28c. Injury at work?

1 Yes 2 X No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Mahmood Shariff

29c. License number

D15165

29d. Date signed (Month, Day, Year)

12/29/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mahmood Shariff, M.D. 105 Aurora Street Cambridge, MD 21613

State  
Registrar

31. Date filed (Month, Day, Year)

DEC 30 1998

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020 Rdb  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Division of Vital Records, P.O. Box 68760,  
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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41443

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) EDWARD THOMAS MOXEY, SR.				2. Date of Death Month Day Year DECEMBER 26, 1998		3. Time of Death 10:50PM						
	4a. Facility Name (If not institution, give street and number) 3822 WANEX ROAD				4b. City, Town, or Location of Death EAST NEW MARKET		4c. County of Death DORCHESTER						
Funeral Director	5. Social Security Number 218-20-7445		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (in yrs. last birthday) 71 Yrs.		8. Date of Birth (Month, Day, Year) MARCH 6, 1927						
	9. Birthplace (State or Foreign Country) MARYLAND		10. Usual Residence of Decedent		11. Under 1 Year Months Days		12. Under 24 Hrs. Hours Min.						
To Be Completed by Funeral Director	10e. State MARYLAND		10b. County DORCHESTER		10c. City, Town or Location EAST NEW MARKET		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						
	10e. Street and Number 3822 WANEX ROAD				10f. Zip Code 21631		10g. Citizen of What Country? USA						
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE						
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) AUTOMOBILE BODY REPAIR		16b. Kind of Business/Industry AUTOMOBILE DEALERSHIP								
	17. Father's Name (First, Middle, Last) JOSEPH NATHANIEL MOXEY				18. Mother's Name (First, Middle, Maiden Surname) MARY KATHERINE LAUCH								
	19a. Informant's Name/Relationship (Type, Print) MAYBELLE M. MOXEY/WIFE				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3822 WANEX ROAD, EAST NEW MARKET, MARYLAND 21631								
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) OUR LADY OF GOOD COUNSEL		20c. Date 12/30		20d. Location - City or Town, State SECRETARY, MARYLAND						
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility ZELLER FUNERAL HOME, 106 MAIN STREET, P.O. BOX 207, EAST NEW MARKET, MD 21631								
	23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												
	<table border="1"> <tr> <td rowspan="4">                 Immediate Cause (Final disease or condition resulting in death)                   Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last             </td> <td>e. <i>Brain aneurysm</i> Due to (or as a consequence of):</td> <td rowspan="4">Approximate Interval Between Onset and Death <i>1 month</i></td> </tr> <tr> <td>b.  Due to (or as a consequence of):</td> </tr> <tr> <td>c.  Due to (or as a consequence of):</td> </tr> <tr> <td>d.  Due to (or as a consequence of):</td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	e. <i>Brain aneurysm</i> Due to (or as a consequence of):	Approximate Interval Between Onset and Death <i>1 month</i>	b. Due to (or as a consequence of):	c. Due to (or as a consequence of):
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	e. <i>Brain aneurysm</i> Due to (or as a consequence of):	Approximate Interval Between Onset and Death <i>1 month</i>											
	b. Due to (or as a consequence of):												
	c. Due to (or as a consequence of):												
	d. Due to (or as a consequence of):												
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.													
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown													
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No													
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No													
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No													
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)													
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. Signature and title of certifier <i>[Signature]</i>				29c. License number 010001675		29d. Date signed (Month, Day, Year) 12/29/98							
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) MARK J. GIZANADA MD BOX 913 SEAFORD DE 19973													
31. Date filed (Month, Day, Year) DEC 30 1998		32. Registrar's Signature <i>[Signature]</i>											

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last)

JEROME D. NILES, JR.

2. Date of Death

Month Day Year

Dec. 29 1998

3. Time of Death

3:20pm

4a. Facility Name (If not institution, give street and number)

9707 Old Georgetown Rd. Apt. # 2508

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

5. Social Security Number

202-07-9495

6. Sex

10M 20F

7. Age (In yrs. last birthday)

84

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

10-7-1914

9. Birthplace (State or Foreign Country)

Delaware

Usual Residence of Decedent

10a. State

Md.

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

9707 Old Georgetown Rd. Apt. #

10f. Zip Code

2508

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married 2 Married  
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No  
If Yes, Give Year or Dates: 44-74

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

US Public Health Service

16b. Kind of Business/Industry

Guard Delaware National

17. Father's Name (First, Middle, Last)

Jerome D. Niles, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Loretta Marjarett Madden

19a. Informant's Name/Relationship (Type, Print)

Joan Tansey

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2823-29th Street N.W., Washington, DC 20008

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State  
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Capitol Cremation 12-31-98 Dover, DELAWARE

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

*[Signature]*

22. Name and Address of Facility

DANIELS & HUTCHISON FUNERAL HOME  
212 N. Broad St., Middletown, DE.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Metastatic Lung Cancer*  
Due to (or as a consequence of):  
(Metastatic Lung Cancer)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

6 mos.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA

28. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 8 Other (Specify)

27. Manner of Death

1 Natural 2 Accident 3 Suicide 4 Homicide  
5 Pending Investigation 6 Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*[Signature]*

29c. License number

D33293

29d. Date signed (Month, Day, Year)

12/30/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. Fred P. Smith 5401 Western Av., Washington, DC 20015-2998

31. Date filed (Month, Day, Year)

JAN 04 1999

32. Registrar's Signature

*[Signature]*

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

1000

1000

1000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

FRANCIS PERRY

2. Date of Death

Month Day Year  
DECEMBER 28, 1998

3. Time of Death

10:15AM

4a. Facility Name (If not institution, give street and number)

ANNE ARUNDEL MEDICAL CENTER

4b. City, Town, or Location of Death

ANNAPOLIS

4c. County of Death

ANNE ARUNDEL

5. Social Security Number

213-22-7450

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

73

Yrs.

If Under 1 Year

Montha Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
MARCH 4, 1998

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

QUEEN ANNE

10c. City, Town or Location

CENTREVILLE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

205 ARMSTRONG AVENUE

10f. Zip Code

21617

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: 1944

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
10

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

FARMHAND

16b. Kind of Business/Industry

AGRICULTURE

17. Father's Name (First, Middle, Last)

EMMETT CHARLES PERRY

18. Mother's Name (First, Middle, Maiden Surname)

EVA CHAMBERS

19a. Informant's Name/Relationship (Type, Print)

BARBARA KILLOUGH/NIECE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P. O. BOX 3, HURLOCK, MARYLAND 21643

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MD. VET. CEM. EASTERN SHORE 12/30

Date

20c. Location - City or Town, State

BEULAH, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

ZELLER FUNERAL HOME, 106 MAIN STREET,  
P.O. BOX 207, EAST NEW MARKET, MARYLAND 21631

23a. Part I. Enter the disease, or condition, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. SEPSIS  
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

10 m/s

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETES, ADULT ONSET

RENAL FAILURE

CO. PD

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Harvey J. Steinfeld MD

29c. License number

D05158

29d. Date signed (Month, Day, Year)

12/29/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HARVEY J. STEINFELD

6171 SHADY SIDE RD  
SHADY SIDE MD 20764

31. Date filed (Month, Day, Year)

JAN 04 1999

32. Registrar's Signature

Geneva B. Sparks

State  
RegistrarBaltimore, Maryland 21215-0020 Eds  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Rena Austin Phillips

2. Date of Death

December 31, 1998

3. Time of Death

0430

4a. Facility Name (If not institution, give street and number)

Laurelwood Continuing Care Center

4b. City, Town, or Location of Death

Elkton

4c. County of Death

Cecil

Funeral  
Director

5. Social Security Number

211-20-4520

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min

8. Date of Birth

February 11, 1920

9. Birthplace (State or Foreign Country)

Delaware

Usual Residence of Decedent

10a. State

Maryland

10b. County

Cecil

10c. City, Town or Location

Elkton

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

100 Laurel Drive

10f. Zip Code

21921

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Salesperson

16b. Kind of Business/Industry

Retail Sales

17. Father's Name (First, Middle, Last)

Leslie Sartin

18. Mother's Name (First, Middle, Maiden Surname)

Grace Heverin

19a. Informant's Name/Relationship (Type, Print)

Janet Meyer/ Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 183, Kenneth Square, Delaware 19348

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hickory Grove Cemetery

Date

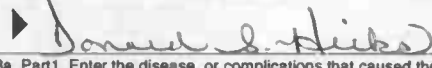
January 4,

1999

20c. Location - City or Town, State

Port Penn, Delaware

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Hicks Home for Funerals, P.A.

103 West Stockton Street, Elkton, Maryland 21921

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Senile Dementia of Alzheimer's Type  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

5 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

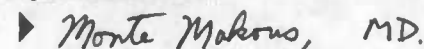
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier



29c. License number

D 44783

29d. Date signed (Month, Day, Year)

December 31, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

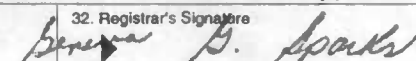
MONTE MAKOUS 111 WEST HIGH STREET, ELKTON, MD 21921

State  
Registrar

31. Date filed (Month, Day, Year)

JAN 04 1999

32. Registrar's Signature



Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

3



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Dorothy W. Reddish

2. Date of Death

Month 12 Day 26 Year 98

3. Time of Death

11:50 AM

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

5. Social Security Number

212-03-4736

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

August 6, 1917

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

Wicomico

10c. City, Town or Location

Salisbury

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

804A College Lane

10f. Zip Code

21804

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Domestic

17. Father's Name (First, Middle, Last)

Augustus White

18. Mother's Name (First, Middle, Maiden Surname)

Viola Kennerly

19a. Informant's Name/Relationship (Type, Print)

William S. Reddish/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1009 Baccharis Dr., Salisbury, MD 21804

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Salisbury Crematory

Date

12/28/98

20c. Location - City or Town, State

Salisbury, MD

21. Signature of Funeral Service Licensee

David H. Thompson M01051

22. Name and Address of Facility

Holloway Funeral Home Professional Association  
501 Snow Hill Rd., Salisbury, MD 21804

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. congestive cardiomyopathy

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

5 days

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

atrial fibrillation

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Charles B. Silvia, Jr MD

29c. License number

D30853

29d. Date signed (Month, Day, Year)

12/26/98

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

Charles B. Silvia, Jr MD

PRMC

31. Date filed (Month, Day, Year)

DEC 30 1998

32. Registrar's Signature

Benita Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

3



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98 41448

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>James Robert Stanley Sr.</b>						2. Date of Death Month <b>December</b> Day <b>31</b> , Year <b>1998</b>			3. Time of Death <b>0632</b>		
4a. Facility Name (If not institution, give street and number) <b>6 Hickory Lane</b>						4b. City, Town, or Location of Death <b>Elkton</b>			4c. County of Death <b>Cecil</b>		
5. Social Security Number <b>222-22-6145</b>		6. Sex <b>1</b> <input checked="" type="checkbox"/> M <b>2</b> <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>57</b> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) <b>December 13, 1941</b>	
9. Birthplace (State or Foreign Country) <b>Maryland</b>											
Usual Residence of Decedent											
10a. State <b>Maryland</b>		10b. County <b>Cecil</b>		10c. City, Town or Location <b>Elkton</b>						10d. Inside City Limits <b>2</b> <input checked="" type="checkbox"/> Yes <b>2</b> <input type="checkbox"/> No	
10e. Street and Number <b>6 Hickory Lane</b>				10f. Zip Code <b>21921</b>				10g. Citizen of What Country? <b>United States</b>			
11. Marital Status <b>1</b> <input type="checkbox"/> Never Married <b>2</b> <input type="checkbox"/> Married <b>3</b> <input type="checkbox"/> Widowed <b>4</b> <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Truck driver</b>				16b. Kind of Business/Industry <b>Concrete</b>			
17. Father's Name (First, Middle, Last) <b>Joe Aron Stanley</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Lydia Amelia Castelow</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Rebecca Wellman/ Daughter</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6 Hickory Lane, Elkton, Maryland 21921</b>					
20a. Method of Disposition <b>1</b> <input type="checkbox"/> Burial <b>2</b> <input checked="" type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State <b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>R.A. Ferris and Company</b>		Date <b>January 5, 1999</b>		20c. Location - City or Town, State <b>West Chester, Pennsylvania</b>			
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility <b>Hicks Home for Funerals, P.A. 103 West Stockton Street, Elkton, Maryland 21921</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. <u>Bledder Cancer</u></b> Due to (or as a consequence of):  <b>b.</b> Due to (or as a consequence of):  <b>c.</b> Due to (or as a consequence of):  <b>d.</b>										Approximate Interval Between Onset and Death <b>3 years</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											
25. Was case referred to medical examiner? <b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No										26. Place of Death (Check only one) Hospital: <b>1</b> <input type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA Other: <b>4</b> <input type="checkbox"/> Nursing Home <b>5</b> <input checked="" type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify)	
27. Manner of Death <b>1</b> <input checked="" type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending Investigation <b>2</b> <input type="checkbox"/> Accident <b>6</b> <input type="checkbox"/> Could not be determined <b>3</b> <input type="checkbox"/> Suicide <b>4</b> <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <b>1</b> <input type="checkbox"/> Yes <b>2</b> <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <b>1</b> <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier <b>Monte Makous, MD</b>						29c. License number <b>D-44783</b>			29d. Date signed (Month, Day, Year) <b>December 31, 1998</b>		
30. Name and address of person who completed cause of death (item 23e) (Type, Print) <b>MONTA MAKOUS 111 West High Street, Elkton, MD 21921</b>											
31. Date filed (Month, Day, Year) <b>JAN 04 1999</b>				32. Registrar's Signature 							

8





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Sarah Jane Sutton

2. Date of Death

Month  
December

Day  
31,

Year  
1998

3. Time of Death

2:00 A.M.

4a. Facility Name (If not institution, give street and number)

576 Blue Ball Road

4b. City, Town, or Location of Death

Elkton

4c. County of Death

Cecil

5. Social Security Number

215-34-6242

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

76

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
February 17, 1922

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Cecil

10c. City, Town or Location

Elkton

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

576 Blue Ball Road

10f. Zip Code

21921

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☐ Married  
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
10

College (14-0r 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Cashier

16b. Kind of Business/Industry

Small Grocery Retail

17. Father's Name (First, Middle, Last)

Earl Nelson Armour

18. Mother's Name (First, Middle, Maiden Surname)

Sarah Jane Lasage

19a. Informant's Name/Relationship (Type, Print)

Hallie M. Edwards / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20 Forsythe Road, Presto, PA 15142

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Ebenezer Cemetery

Date

Jan. 3 1999

20c. Location - City or Town, State

Rising Sun, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Crouch Funeral Home

127 South Main Street, North East, MD 21901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. RESPIRATORY FAILURE

Approximate Interval Between Onset and Death

1 wk

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. CHRONIC OBSTRUCTIVE LUNG DISEASE

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☒ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA

Other:

☐ Nursing Home ☒ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 44102

29d. Date signed (Month, Day, Year)

12/31/98

30. Name and address of person who completed cause of death (item 23e) (Type, Print)

Wm. RENZULLI M.D. 901 WARBURTON RD ELKTON MD 21921

31. Date filed (Month, Day, Year)

DEC 31 1998

32. Registrar's Signature

Beverly G. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 41450

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Fred Elmer South</b>				2. Date of Death Month <b>December</b> Day <b>29</b> , Year <b>1998</b>				3. Time of Death <b>0105</b>		
	4a. Facility Name (If not institution, give street and number) <b>Sunrise Care and Rehabilitation</b>				4b. City, Town, or Location of Death <b>Elkton</b>				4c. County of Death <b>Cecil</b>		
Funeral Director	5. Social Security Number <b>169-22-8252</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>70</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>March 5, 1928</b>		9. Birthplace (State or Foreign Country) <b>Kentucky</b>		
	Usual Residence of Decedent				10c. City, Town or Location <b>Elkton</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
10e. State <b>Maryland</b>		10b. County <b>Cecil</b>		10f. Zip Code <b>21921</b>				10g. Citizen of What Country? <b>United States</b>			
10e. Street and Number <b>2823 Singerly Road</b>											
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b>		College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Custodian</b>				16b. Kind of Business/Industry <b>University of Delaware</b>			
17. Father's Name (First, Middle, Last) <b>Tobe South</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Aughtha Sexton</b>							
19a. Informant's Name/Relationship (Type, Print) <b>Freda M. Spence/ Sister</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2823 Singerly Road, Elkton, Maryland 21921</b>							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Cherry Hill Methodist Cemetery</b>		Data <b>December 31, 1998</b>		20c. Location - City or Town, State <b>Cherry Hill, Maryland</b>					
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Hicks Home for Funerals, P.A. 103 West Stockton Street, Elkton, Maryland 21921</b>							
23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <b>SEPTICEMIA</b> Due to (or as a consequence of): b. <b>PNEUMONIA</b> Due to (or as a consequence of): c. <b>DECUBITUS ULCER</b> Due to (or as a consequence of): d. <b>CEREBROVASCULAR ACCIDENT</b>								Approximate Interval Between Onset and Death <b>3 DAYS</b> <b>1 MONTH</b> <b>1 MONTH</b> <b>10 MONTHS</b>			
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		26. Place of Death (Check only one) Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>D07463</b>		29d. Date signed (Month, Day, Year) <b>12-29-98</b>					
30. Name and address of person who completed causa of death (Item 23e) (Type, Print) <b>Rolando Najera M.D. 111 West High Street, Elkton, Maryland 21921</b>											
31. Date filed (Month, Day, Year) <b>DEC 30 1998</b>		32. Registrar's Signature 									

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

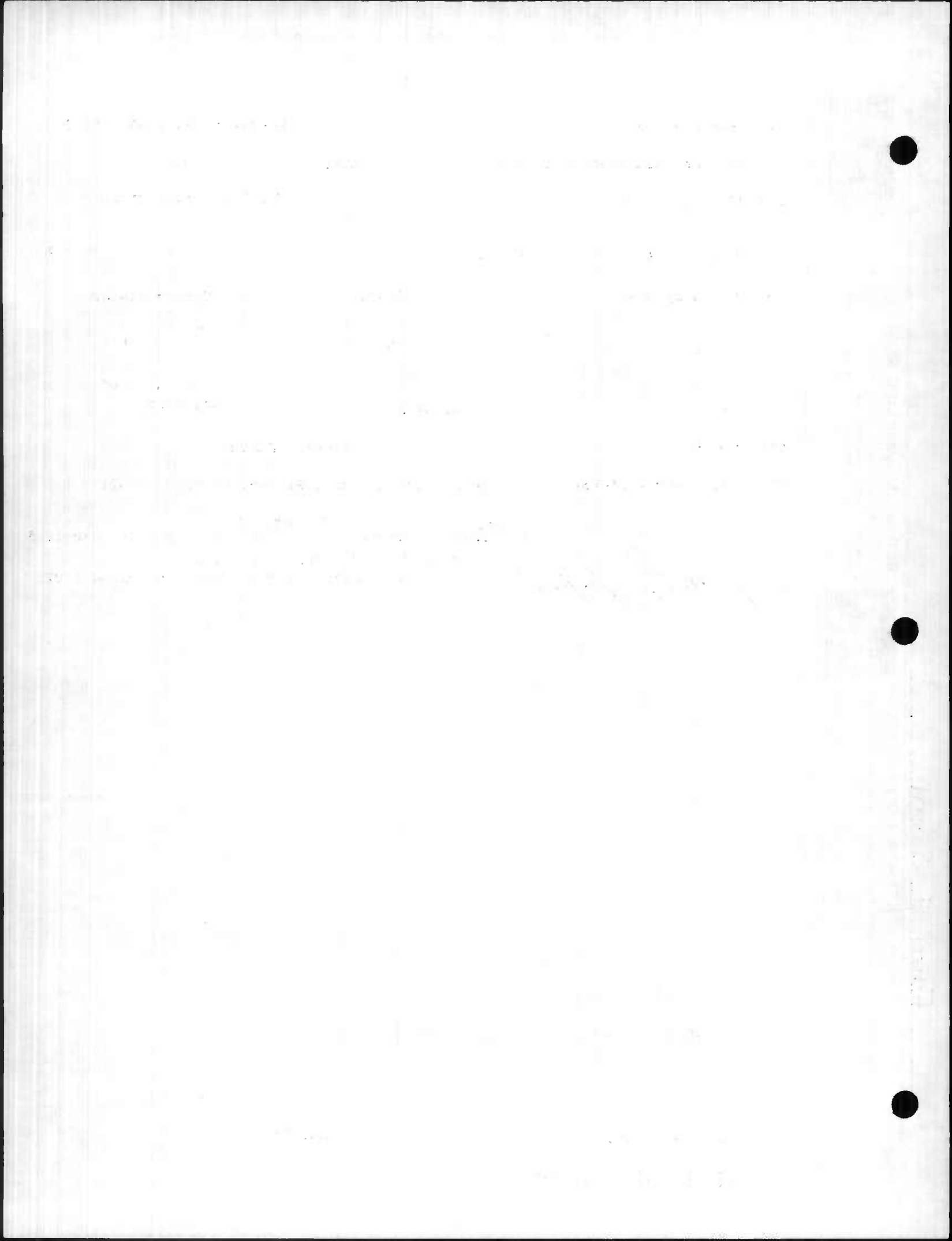
Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

FRED E. SOUTH

Division of Vital Records, P.O. Box 68760, LVT

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Dorothy C. Smith</i>				2. Date of Death Month <i>December</i> Day <i>27</i> Year <i>1998</i>		3. Time of Death <i>1320</i>	
	4a. Facility Name (If not institution, give street and number) <i>PENINSULA REGIONAL MEDICAL CENTER</i>				4b. City, Town, or Location of Death <i>SALISBURY</i>		4c. County of Death <i>WICOMICO</i>	
Funeral Director	5. Social Security Number <i>215-18-1893</i>		8. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>86</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day, Year <i>Feb. 12/1917</i>	9. Birthplace (State or Foreign Country) <i>Virginia</i>
	Usual Residence of Decedent							
10a. State <i>md.</i>		10b. County <i>Wicomico</i>		10c. City, Town or Location <i>Salisbury</i>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <i>27474 Log Cabin Rd.</i>				10f. Zip Code <i>21801</i>		10g. Citizen of What Country? <i>USA</i>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4or 5+) <i>4</i>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Civil Investigation</i>		16b. Kind of Business/Industry <i>US Government</i>		
17. Father's Name (First, Middle, Last) <i>JAMES Goode</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>CLARA JAMES Goode</i>				
19a. Informant's Name/Relationship (Type, Print) <i>Rev Thomas G. Smith Husband</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>27474 Log Cabin Rd. Salisbury Md 21801</i>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Arbutus Cemetery</i>		Date <i>1/4/98</i>		20c. Location - City or Town, State <i>Baltimore Md.</i>
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <i>BANDON SOUTH #14</i> <i>Seaside Hwy Salisbury Md.</i>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <i>Sepsis.</i> Due to (or as a consequence of): <i>AV graft.</i> Due to (or as a consequence of): <i>ESAD &amp; HD.</i> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>HTN.</i>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>William Neghedar</i>		29c. License number <i>53611</i>		29d. Date signed (Month, Day, Year) <i>12/27/98.</i>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>547-G Riverside Dr. Salisbury, MD 21801</i>								
31. Date filed (Month, Day, Year) <i>DEC 30 1998</i>				32. Registrar's Signature <i>Barbara A. Sparks</i>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amended Item #19b, per F.D. State of Maryland / Department of Health and Mental Hygiene  
12/23/98, Carroll County, wjl

Certificate of Death

Reg. No.

98 41452

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Susanne Smutek</i>				2. Date of Death Month <i>Dec</i> Day <i>21</i> Year <i>1998</i>		3. Time of Death <i>9:30 pm</i>	
	4a. Facility Name (If not institution, give street and number) <i>University Hospital</i>				4b. City, Town, or Location of Death <i>Baltimore</i>		4c. County of Death <i>Baltimore City</i>	
Funeral Director	5. Social Security Number <i>216 80 9057</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (in yrs. last birthday) <i>39</i>	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>Oct. 12, 1959</i>	9. Birthplace (State or Foreign Country) <i>Maryland</i>
	Usual Residence of Decedent							
10a. State <i>Md.</i>		10b. County <i>Carroll</i>		10c. City, Town or Location <i>Eldersburg</i>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <i>631 Fern Way</i>				10f. Zip Code <i>21784</i>		10g. Citizen of What Country? <i>U.S.A.</i>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <i>white</i>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Office Assistant</i>			16b. Kind of Business/Industry <i>Lawyer Office</i>	
17. Father's Name (First, Middle, Last) <i>Jack McGehrin</i>					18. Mother's Name (First, Middle, Maiden Surname) <i>Catherine McGourn</i>			
19a. Informant's Name/Relationship (Type, Print) <i>James Smutek (Husband)</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>631 Fern Way, Sykesville, MD 21784</i> <del>Haight Funeral Home &amp; Chapel P.O. Box 195</del>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Crest Lawn Mem. Gardens</i>			Date <i>12/24/98</i>		20c. Location - City or Town, State <i>Marriottsville, Md.</i>	
21. Signature of Funeral Service Licensee <i>Henry W. Haight</i>				22. Name and Address of Facility <i>Sykesville, Md. 21784</i> <i>Haight Funeral Home &amp; Chapel P.O. Box 195</i>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death
a. <i>Cerebral herniation syndrome</i> Due to (or as a consequence of):								<i>48 H</i>
b. <i>meningitis</i> Due to (or as a consequence of):								<i>48 H</i>
c. _____ Due to (or as a consequence of):								
d. _____ Due to (or as a consequence of):								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
							24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA			26. Place of Death (Check only one) Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <i>Dr. Ciatolla</i>				29c. License number <i>MD476435C10001</i>		29d. Date signed (Month, Day, Year) <i>Dec. 21, 1998</i>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <i>DR. CIATOLLA</i> <i>22 S. Green Street BALTIMORE, MD 21201</i>								
31. Date filed (Month, Day, Year) <i>DEC 23 1998</i>		32. Registrar's Signature <i>B. Sparks</i>						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 41453

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>WALTER WALLACE TRICE</b>				2. Date of Death Month Day Year <b>December 29, 1998</b>		3. Time of Death <b>0515</b>
	4a. Facility Name (If not Institution, give street and number) <b>PENINSULA REGIONAL MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>SALISBURY</b>		4c. County of Death <b>WICOMICO</b>
Funeral Director	5. Social Security Number <b>218-24-4765</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>69</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>July 10, 1929</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent						
10a. State <b>Maryland</b>		10b. County <b>Wicomico</b>		10c. City, Town or Location <b>Salisbury</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>7533 Titleist Drive</b>				10f. Zip Code <b>21801</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>Korea</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> Collega (1-4or 5+) <b>-</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Truck Driver</b>		16b. Kind of Business/Industry <b>Trucking</b>	
17. Father's Name (First, Middle, Last) <b>William Benjamin Trice</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Bertie Murphy</b>			
19a. Informant's Name/Relationship (Type, Print) <b>David A. Trice/Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7533 Titleist Dr., Salisbury, MD 21801</b>			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Salisbury Crematory</b>		Date <b>12/30/98</b>		20c. Location - City or Town, State <b>Salisbury, MD</b>	
21. Signature of Funeral Service Licensee <b>WR/Chadwick</b>				22. Name and Address of Facility <b>Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediata Causa (Final disease or condition resulting in death)  a. <b>SEPSIS</b> Due to (or as a consequence of):  b. <b>ABVER &amp; SPLEEN ABSCESS</b> Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediata causa. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death <b>7-10 DAY</b> <b>7-10 DAY</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. <b>LHF; LOID</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier <b>D J Chadwick</b>				29c. License number <b>020912</b>		29d. Date signed (Month, Day, Year) <b>12-29-98</b>	
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) <b>Dennis J. Chadwick M.D. 400 EASTERN SHORE DR. SALISBURY MD 21804</b>							
31. Date filed (Month, Day, Year) <b>DEC 31 1998</b>				32. Registrar's Signature <b>B Sparks</b>			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

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Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene 98 41454

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>CALVIN B. TAYLOR</b>						2. Date of Death Month <b>DEC.</b> Day <b>30</b> Year <b>1998</b>		3. Time of Death <b>1:50 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>7327 CANAL STREET</b>						4b. City, Town, or Location of Death <b>WILLARDS</b>		4c. County of Death <b>WICOMICO</b>	
Funeral Director	5. Social Security Number <b>215-20-4470</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) Yrs.		8. Date of Birth (Month, Day, Year) <b>OCT. 20, 1925</b>		9. Birthplace (State or Foreign Country) <b>MARYLAND</b>	
	10a. State <b>MARYLAND</b>		10b. County <b>WICOMICO</b>		10c. City, Town or Location <b>WILLARDS</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
To Be Completed by Funeral Director	10e. Street and Number <b>7327 CANAL STREET</b>				10f. Zip Code <b>21874</b>		10g. Citizen of What Country? <b>USA</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>			
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>FOREMAN</b>		16b. Kind of Business/Industry <b>COUNTY ROADS</b>			
	17. Father's Name (First, Middle, Last) <b>JOSEPH TAYLOR</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>ESSIE LEWIS</b>					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>MAE F. TAYLOR/WIFE</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7327 CANAL STREET, WILLARDS, MARYLAND 21874</b>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>NEW HOPE CEMETERY</b>		20c. Date <b>1/3/99</b>		20d. Location - City or Town, State <b>WILLARDS, MARYLAND</b>			
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>HASTINGS FUNERAL HOME, SELBYVILLE, DELAWARE 19975</b>					
	23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>CORONARY ARTERY DISEASE</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								Approximate Interval Between Onset and Death <b>3 YRS.</b>	
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CVA</b>						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>029168</b>		29d. Date signed (Month, Day, Year) <b>12/31/98</b>			
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>DR. Robert B. Allen, 100 Power St. Salisbury Md 21801</b>									
State Registrar	31. Date filed (Month, Day, Year) <b>DEC 31 1998</b>		32. Registrar's Signature 							



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41455

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JACK TERENCE BELL</b>				2. Date of Death Month Day Year <b>DEC 30 1998</b>		3. Time of Death <b>12:30 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>NATIONAL NAVAL MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>BETHESDA</b>		4c. County of Death <b>MONTGOMERY</b>	
Funeral Director	5. Social Security Number <b>N/A</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) Yrs. Months Days <b>4 47</b>		8. Date of Birth (Month, Day, Year) <b>Dec. 29, 1998</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>MD</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Rockville</b>	
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>13219 Superior Street</b>		10f. Zip Code <b>20853</b>		
10g. Citizen of What Country? <b>USA</b>		11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>0</b> College (1-4 or 5+) <b>0</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Infant</b>		16b. Kind of Business/Industry <b>Infant</b>		
17. Father's Name (First, Middle, Last) <b>Jonathon Bell</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Theresa Ann Quane</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Jonathon Bell/Father</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>13219 Superior Street, Rockville, Maryland 20853</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Baltimore Washington Cr.</b>		20c. Date <b>1/13/99</b>		20d. Location - City or Town, State <b>Laurel, Maryland</b>		
21. Signature of Funeral Service Licensee		22. Name and Address of Facility <b>Fleck Funeral Home, Inc.</b> <b>7601 Sandy Spring Road, Laurel, Maryland 20707</b>		23a. Part I. Enter the diseases or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>EXTREME PREMATUREITY</b> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last				
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				
28a. Date of Injury (Month, Day, Year)				28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <b>Jeffrey Greenwald</b>		29c. License number <b>D-44634</b>		
29d. Date signed (Month, Day, Year) <b>12/30/98</b>				30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>NATIONAL NAVAL MEDICAL CENTER</b> <b>BETHESDA MD 20889-5600</b>				
31. Date filed (Month, Day, Year) <b>JAN 14 1999</b>				32. Registrar's Signature <b>[Signature]</b>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





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State of Maryland / Department of Health and Mental Hygiene

98 41456

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Rose Reiswig Gerringer				2. Date of Death Month Day Year December 28, 1998				3. Time of Death 1205 PM		
	4a. Facility Name (If not institution, give street and number) 11111 Green Spring Avenue				4b. City, Town, or Location of Death Lutherville				4c. County of Death Baltimore		
Funeral Director	5. Social Security Number 353-15-3112		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 92 Yrs.		8. Date of Birth (Month, Day, Year) Jan. 18, 1906		9. Birthplace (State or Foreign Country) Colorado		
	Usual Residence of Decedent										
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Lutherville				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
10e. Street and Number 11111 Green Spring Avenue				10f. Zip Code 21093				10g. Citizen of What Country? U.S.A.			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+) 4				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Teacher				16b. Kind of Business/Industry School			
17. Father's Name (First, Middle, Last) George Reiswig					18. Mother's Name (First, Middle, Maiden Surname) Alice Kammerzell						
19a. Informant's Name/Relationship (Type, Print) Rose Alice Gerringer/daughter					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11111 Green Spring Avenue, Lutherville, Maryland 21093						
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place)		Date		20c. Location - City or Town, State				
21. Signature of Funeral Service Licensee Ronald S. Wade, Director					22. Name and Address of Facility State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201						
23a. Part I. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ASCVD Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.										Approximate Interval Between Onset and Death 2 yrs.	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Demerol								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier [Signature]				29c. License number D-12990				29d. Date signed (Month, Day, Year) 1/6/99			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James A. QUINLAN, MD 7801 YACHT RD TOWSON MD 21204											
31. Date filed (Month, Day, Year) JAN 14 1999		32. Registrar's Signature [Signature]									

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41457

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>El, Minnick</u>						2. Date of Death Month <u>Dec</u> Day <u>28</u> Year <u>1998</u>		3. Time of Death <u>1810</u>		
	4a. Facility Name (If not institution, give street and number) <u>3801 Bell Road</u>						4b. City, Town, or Location of Death <u>Burtonsville</u>		4c. County of Death <u>Montgomery</u>		
Funeral Director	5. Social Security Number <u>212-34-3384</u>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <u>61</u> Yrs.		8. Date of Birth (Month, Day, Year) <u>Feb. 12, 1937</u>		9. Birthplace (State or Foreign Country) <u>Maryland</u>		
	Usual Residence of Decedent										
10a. State <u>MD</u>		10b. County <u>Montgomery</u>		10c. City, Town or Location <u>Burtonsville</u>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number <u>3801 Bell Road</u>				10f. Zip Code <u>20866</u>				10g. Citizen of What Country? <u>USA</u>			
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <u>White</u>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>8</u> College (1-4 or 5+) <u>0</u>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Sheet Metal Worker</u>				16b. Kind of Business/Industry <u>Factory</u>			
17. Father's Name (First, Middle, Last) <u>Lucian D. Minnick</u>						18. Mother's Name (First, Middle, Maiden Surname) <u>Mamie E. Hume</u>					
19a. Informant's Name/Relationship (Type, Print) <u>Ruth Bayne/Sister</u>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>3801 Bell Road, Burtonsville, MD 20866</u>					
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <u>New Hope Bapt. Ch. Cem.</u>		Date <u>12/31/98</u>		20c. Location - City or Town, State <u>Mine Run, Virginia</u>			
21. Signature of Funeral Service Licensee <u>Thomas E. Hume</u>				22. Name and Address of Facility <u>Fleck Funeral Home, Inc.</u> <u>7601 Sandy Spring Road, Laurel, MD 20707</u>							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death	
Immediate Cause (Final disease or condition resulting in death) a. <u>Inanition</u> Due to (or as a consequence of):										DME	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. <u>Pneumonia</u> Due to (or as a consequence of):											
c. _____ Due to (or as a consequence of):											
d. _____ Due to (or as a consequence of):											
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown			
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier <u>Dr. M. Brecher, MD DME</u>						29c. License number <u>D00428</u>		29d. Date signed (Month, Day, Year) <u>Dec 28, 1998</u>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>IRA N. BRECHER, MD DME</u> <u>2101 Medical Park Dr</u> <u>Silver Spring MD 20902</u>											
31. Date filed (Month, Day, Year) <u>JAN 14 1999</u>				32. Registrar's Signature <u>B. Sparks</u>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last) <b>EZZARD ROBINSON</b>		2. Date of Death Month <b>DECEMBER</b> Day <b>31<sup>st</sup></b> Year <b>1998</b>		3. Time of Death <b>12.05P</b>
4a. Facility Name (If not institution, give street and number) <b>MARYLAND GENERAL HOSPITAL</b>		4b. City, Town, or Location of Death <b>BALTIMORE CITY</b>		4c. County of Death <b>Baltimore City</b>
5. Social Security Number <b>577-56-5642</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>57</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
8. Date of Birth (Month, Day, Year) <b>July 28, 1941</b>		9. Birthplace (State or Foreign Country) <b>unknown</b>		
Usual Residence of Decedent				
10a. State <b>Maryland</b>	10b. County <b>Baltimore City</b>	10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number <b>501 West Franklin Street</b>		10f. Zip Code <b>21201</b>		10g. Citizen of What Country? <b>U.S.A.</b>
11. Marital Status <input checked="" type="checkbox"/> Navar Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>unknown</b> College (1-4 or 5+) <b>unknown</b>		
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>unknown</b>		16b. Kind of Business/Industry <b>unknown</b>		
17. Father's Name (First, Middle, Last) <b>unknown</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>unknown</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Philip Govan/cousin</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>12900 Tobacco Trail Lane, Brandywine, Maryland 20613</b>		
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <b>in state</b>		20b. Place of Disposition (Name of cemetery, crematory or other place)		20c. Location - City or Town, State
21. Signature of Funeral Service Licensee <b>Ronald S. Wade, Director</b>		22. Name and Address of Facility <b>State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. BRONCHOPNEUMONIA</b> Due to (or as a consequence of): <b>b. SEPSIS</b> Due to (or as a consequence of): <b>c. ENDOCARDITIS</b> Due to (or as a consequence of): <b>d.</b>				Approximate Interval Between Onset and Death <b>DAYS</b> <b>WEEKS</b> <b>WEEKS</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. <b>SEVERE ANEMIA</b>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury <b>M</b>	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
29b. Signature and title of certifier <b>Vasanthakumar</b>		29c. License number <b>D42510</b>		29d. Date signed (Month, Day, Year) <b>DECEMBER 31<sup>st</sup> 1998</b>
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) <b>M. VASANTHAKUMAR MD, 821 N. EUTAW ST. # 407, MD 21201</b>				
31. Date filed (Month, Day, Year)		32. Registrar's Signature <b>▶</b>		

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41459

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ruth Osgerby Strong				2. Date of Death Month Day Year December 20, 1998				3. Time of Death 10:00 AM	
	4a. Facility Name (If not institution, give street and number) Friends Nursing Home				4b. City, Town, or Location of Death Sandy Spring				4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 311-42-4686	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Oct. 23, 1914		9. Birthplace (State or Foreign Country) West Virginia		
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland	10b. County Montgomery	10c. City, Town or Location Sandy Spring				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	10e. Street and Number 1015 Quaker Knoll Road				10f. Zip Code 20860		10g. Citizen of What Country? U.S.A.			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home				
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Earl William Osgerby				18. Mother's Name (First, Middle, Maiden Surname) Carrie Neilson					
	19a. Informant's Name/Relationship (Type, Print) Laurence E. Strong/husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1015 Quaker Knoll Road, Sandy Spring, Maryland 20860					
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date		20c. Location - City or Town, State			
	21. Signature of Funeral Service Licensee Ronald S. Wade, Director				22. Name and Address of Facility State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. OLIVIO PONTINE DEGENERATION Due to (or as a consequence of):								Approximate Interval Between Onset and Death MONTHS	
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	29b. Signature and title of certifier				29c. License number D38457		29d. Date signed (Month, Day, Year) JANUARY 4, 1999			
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NAKUL GOYAL MD 1811 PRINCE PHILIP DR #328, CLAY MD 20832									
	31. Date filed (Month, Day, Year) JAN 14 1999		32. Registrar's Signature B. Sparks							





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Baby Girl "B" Buchi'Ahiabuiké

2. Date of Death

Month Day Year  
December 12, 1998

3. Time of Death

10:20 am

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Sinai Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

5. Social Security Number

None

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

December 12, 1998

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

42 Wyndmoor Place

10f. Zip Code

21207

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

0

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

N/A

16b. Kind of Business/Industry

N/A

17. Father's Name (First, Middle, Last)

Smithison Omye Buchi'Ahiabuiké

18. Mother's Name (First, Middle, Maiden Surname)

Chinyere Hope Ezirim

19a. Informant's Name/Relationship (Type, Print) (Mother)

Chinyere Buchi'Ahiabuiké

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

42 Wyndmoor Place Baltimore, MD 21207

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Sinai Hospital

Date

12-14-98

20c. Location - City or Town, State

Baltimore, MD 21215

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Sinai Hosp

2401 W. BELVEDERE AVE

23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

e. Extreme Prematurity

Due to (or as a consequence of):

b. Premature Rupture of Membranes

Due to (or as a consequence of):

c. Chorioamnitis

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy

performed?

1 ☒ Yes 2 ☐ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No

25. Was case referred to medical

examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending

investigation

2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day Year)

N/A

28b. Time of

Injury

N/A

28c. Injury at

Work?

1 ☐ Yes 2 ☒ No

28d. Describe how Injury occurred

N/A

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

N/A

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)

N/A

29e. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D0051180

29d. Date signed (Month, Day, Year)

December 12, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gloria Bowles-Johnson, MD 2401 W. Belvedere Ave. Baltimore, MD 21215

31. Date filed (Month, Day, Year)

JAN 15 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

98-41461

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Baby Boy "C" Buchi 'Ahiabuiki</b>				2. Date of Death Month <b>December</b> Day <b>12</b> Year <b>1998</b>				3. Time of Death <b>10:25 am</b>	
	4a. Facility Name (If not Institution, give street and number) <b>Sinai Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore City</b>				4c. County of Death	
Funeral Director	5. Social Security Number <b>None</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) Yrs. _____		If Under 1 Year Months _____ Days _____		If Under 24 Hrs. Hours _____ Min. _____	
	8. Date of Birth (Month, Day, Year) <b>December 12, 1998</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>MD</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location	
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>42 Wyndmoor Place</b>		10f. Zip Code <b>21207</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>0</b> College (1-4or 5+) <b>Collega</b>		
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>N/A</b>		16b. Kind of Business/Industry <b>N/A</b>		17. Father's Name (First, Middle, Last) <b>Smithison Omye Buchi'Ahiabuiki</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Chinyere Hope Ezirim</b>		19a. Informant's Name/Relationship (Type, Print) (Mother) <b>Chinyere Hope Ezirim</b>		
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>42 Wyndmoor Place Baltimore, Maryland 21207</b>		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Sinai Hospital</b>		20c. Location - City or Town, State <b>Baltimore, Maryland</b>		20d. Date <b>12-14-98</b>		
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>SINAI HOSP 2401 W. BELVEDERE AVE</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <b>Extreme Prematurity</b> Due to (or as a consequence of):  <b>Premature rupture of membranes</b> Due to (or as a consequence of):  <b>Chorioamnitis</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>N/A</b>		28b. Time of Injury <b>N/A</b>		
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>N/A</b>		28e. Location (Street and Number or Rural Route Number, City or Town, State) <b>N/A</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>N/A</b>				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) as stated.		29b. Signature and title of certifier 		29c. License number <b>D0051180</b>		29d. Date signed (Month, Day, Year) <b>December 12, 1998</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Gloria Bowles-Johnson, MD 2401 W. Belvedere Ave. Baltimore, MD 21215</b>		31. Date filed (Month, Day, Year) <b>JAN 15 1999</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



98 41462

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>DELMARIO SHAWAYNE HAGLER</b>						2. DATE OF DEATH MONTH <b>12</b> DAY <b>7</b> YEAR <b>98</b>		3. TIME OF DEATH <b>2:36 A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>NONE</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) YRS.		7. DATE OF BIRTH (Month, Day, Year) MONTH <b>12</b> DAY <b>7</b> YEAR <b>98</b>		8. BIRTHPLACE (State or Foreign Country) <b>MARYLAND</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>PRINCE GEORGES HOSPITAL CENTER</b>						9b. CITY, TOWN OR LOCATION OF DEATH <b>CHEVERLY</b>		9c. COUNTY OF DEATH <b>PRINCE GEORGES</b>	
10a. STATE <b>MARYLAND</b>						10b. COUNTY <b>PRINCE GEORGES</b>		10c. CITY, TOWN OR LOCATION <b>SEAT PLEASANT</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO						10e. STREET AND NUMBER <b>502 - 62ND PLACE, APT. C</b>			
10f. ZIP CODE <b>20743</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>INFANT</b>		16b. KIND OF BUSINESS/INDUSTRY <b>INFANT</b>			
17. FATHER'S NAME (First, Middle, Last) <b>MYRON DELMARIO HAGLER</b>						18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>DAWN LATRESE BLAKE</b>			
19a. INFORMANT'S NAME (Type/Print) <b>PRINCE GEORGES HOSP. CTR.</b>						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3001 HOSPITAL DRIVE, CHEVERLY MD 20785</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>PRINCE HOSP CHEVERLY MD</b>		20c. LOCATION — City or Town, State <b>CHEVERLY MD</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>ALLIANCE 1-199</b>						22. NAME AND ADDRESS OF FACILITY <b>PRINCE CHEVERLY MD 20785</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Prematurely</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Incompetent Cervix</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. b. c. d.  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>									Approximate Interval Between Onset and Death
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						29b. SIGNATURE AND TITLE OF CERTIFIER <b>MEMICADO MD</b>			
29c. LICENSE NUMBER <b>D3917</b>						29d. DATE SIGNED (Month, Day, Year) <b>1-8-99</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>NKODO MARIE-CHRISTINE</b>									
31. DATE FILED (Month, Day, Year) <b>JAN 15 1999</b>				32. REGISTRAR'S SIGNATURE <b>Beverly B. Sparks</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41463

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Baby Boy Nickles

2. Date of Death

December 15 1998

3. Time of Death

2:17 A.M.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

5. Social Security Number

none

6. Sex

M 2 F

7. Age (in yrs. last birthday)

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Dec. 15, 1998

9. Birthplace (State or Foreign Country)

Baltimore

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore County

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

8114 Analee Avenue

10f. Zip Code

21237

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 Never Married 2 Married

3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 Yes 2 No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

0

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

b

none

16b. Kind of Business/Industry

none

17. Father's Name (First, Middle, Last)

unknown

18. Mother's Name (First, Middle, Maiden Surname)

Denise Nickles

19a. Informant's Name/Relationship (Type, Print)

Denise Nickles/mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8114 Analee Avenue, Baltimore, Maryland 21237

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State

4 Donation 5 Other (Specify) in state

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board, 655 W. Baltimore Street

Baltimore, Maryland 21201

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Prematurity

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 Minutes

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

Hospital:

1 Inpatient

2 ER/Outpatient

3 DOA

26. Place of Death (Check only one)

Other:

4 Nursing Home

5 Residence

6 Other (Specify)

27. Manner of Death

1 Natural

2 Accident

3 Suicide

4 Homicide

5 Pending Investigation

6 Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician:

2 Medical Examiner:

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

P. Richardson

29c. License number

RD 187393

29d. Date signed (Month, Day, Year)

December 15, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr Patricia Richardson 9000 Franklin Square Drive Baltimore, MD 21237

31. Date filed (Month, Day, Year)

JAN 15 1999

32. Registrar's Signature

B. Sparks

State  
RegistrarNickles, Babyboy  
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-4 show injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1-22-99 WR

ITEMS: #11, 15, 16A-B, 20A-C, 21, 22 PER F.H G767

## Certificate of Death

Reg. No.

98 41464

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Paul E. Russell</u>				2. Date of Death Month Day Year <u>December 20, 1998</u>				3. Time of Death <u>9:50 PM</u>	
	4a. Facility Name (If not institution, give street and number) <u>1722 West Pratt Street</u>				4b. City, Town, or Location of Death <u>Baltimore</u>				4c. County of Death <u>Baltimore City</u>	
Funeral Director	5. Social Security Number <u>315-38-3859</u>		6. Sex <u>15</u> M <u>2</u> F		7. Age (In yrs. last birthday) <u>72</u> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) <u>Oct. 16, 1926</u>		9. Birthplace (State or Foreign Country) <u>Ohio</u>		10a. State <u>Maryland</u>		10b. County <u>Baltimore City</u>		10c. City, Town or Location <u>Baltimore</u>	
Usual Residence of Decedent		10d. Inside City Limits <u>1</u> Yes <u>2</u> No		10e. Street and Number <u>1722 West Pratt Street</u>		10f. Zip Code <u>21223</u>		10g. Citizen of What Country? <u>U.S.A.</u>		
11. Marital Status <u>unknown</u> 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>Black</u>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>unknown</u> 2 GRADE College (1-4 or 5+) <u>unknown</u> NA		
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>unknown</u> LABORER		16b. Kind of Business/Industry <u>unknown</u> VARIOUS TRADES		17. Father's Name (First, Middle, Last) <u>unknown</u>		18. Mother's Name (First, Middle, Maiden Surname) <u>unknown</u>		19a. Informant's Name/Relationship (Type, Print) <u>Sheila Patterson/niece</u>		
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>1722 West Pratt Street, Baltimore, Maryland 21223</u>		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) <u>in state</u>		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>GARRISON FOREST VA CEMETERY</u>		20c. Location - City or Town, State <u>1-15-99 OWINGS MILLS, MD</u>		21. Signature of Funeral Service Licensee <u>Ronald S. Wade, Director</u> DONALD GAITHER		
22. Name and Address of Facility <u>WM. C. MARCH FUNERAL HOME</u> <u>1101 E. NORTH AVE. BALTIMORE, MD 21202</u> <u>Baltimore, Maryland 21201 21202</u>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <u>Malignant Arrhythmia</u> Due to (or as a consequence of): b. <u>Coronary artery disease</u> Due to (or as a consequence of): c. <u>Myocardial Ischemia</u> Due to (or as a consequence of): d. <u>Dilated Cardiomyopathy</u>		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <u>1-15-99</u>		
28b. Time of Injury <u>M</u>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <u>[Signature]</u>		29c. License number <u>D32778</u>		29d. Date signed (Month, Day, Year) <u>1/7/99</u>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>SEAN T. GLOTH, M.D. 5900 CEDAR LANE, Columbia, MD 21044</u>		
31. Date filed (Month, Day, Year) <u>JAN 15 1999</u>		32. Registrar's Signature <u>[Signature]</u>		33. State Registrar		34. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020		35. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.		



98 4/11/65

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Babyboy Jeffrey Via</i>				2. DATE OF DEATH MONTH <i>12</i> DAY <i>09</i> YEAR <i>98</i>		3. TIME OF DEATH <i>0718<sup>00</sup> A M</i>	
4. SOCIAL SECURITY NUMBER <i>NONE</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) YRS. MONTHS DAYS <i>1 20</i>		7. DATE OF BIRTH (Month, Day, Year) <i>10/21/98</i>	
8a. FACILITY NAME (If not Institution, give street and number) <i>PRINCE GEORGES HOSPITAL CENTER</i>				8b. CITY, TOWN OR LOCATION OF DEATH <i>CHEVERLY</i>		8c. COUNTY OF DEATH <i>PRINCE GEORGES</i>	
10a. STATE <i>MD</i>				10b. COUNTY <i>PRINCE GEORGES</i>		10c. CITY, TOWN OR LOCATION <i>LANDOVER</i>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <i>2515 KENT TOWN PLACE</i>			
10f. ZIP CODE <i>20785</i>				10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>BLACK</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>0</i> College (1-4 or 5+) <i>0</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>INFANT</i>		16b. KIND OF BUSINESS/INDUSTRY <i>INFANT</i>			
17. FATHER'S NAME (First, Middle, Last) <i>LAMONT RENE WILLIS</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>JACQUITA E. VIA</i>			
19a. INFORMANT'S NAME (Type/Print) <i>PRINCE GEORGES HOSPITAL CTR.</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3001 HOSPITAL DRIVE, CHEVERLY, MD 20785</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (If not in cemetery, crematory or other place) <i>PGHC, CHEVERLY, MD</i>		20c. LOCATION — City or Town, State <i>PGHC, CHEVERLY, MD</i>		20d. DATE <i>12/09/98</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <i>PGHC, CHEVERLY, MD 20785</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>a. Severe bronchopulmonary dysplasia</i>							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>b. Extreme prematurity</i>							
DUE TO (OR AS A CONSEQUENCE OF):							
DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> A <input type="checkbox"/> P <input type="checkbox"/> N		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Laura L. Jennings, MD, Neonatologist</i>				29c. LICENSE NUMBER <i>D47737</i>		29d. DATE SIGNED (Month, Day, Year) <i>12/09/98</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>LAURA L. JENNINGS, MD, PEDS DEPT., 3001 HOSPITAL DRIVE, CHEVERLY, MD 20785</i>							
31. DATE FILED (Month, Day, Year) <i>JAN 15 1999</i>		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 41466

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Clyde Douglas Asbury</b>				2. Date of Death Month Day Year <b>DEC. 22, 1998</b>		3. Time of Death <b>0920 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>24344 FLAMINGO TERRACE</b>				4b. City, Town, or Location of Death <b>GAITHERSBURG</b>		4c. County of Death <b>MONTGOMERY</b>	
Funeral Director	5. Social Security Number <b>212-54-4880</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>49</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>October 17, 1949</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Gaithersburg</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>24344 Flamingo Terrace</b>		10f. Zip Code <b>20882</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (14 or 5+) <b></b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Landscaper</b>		16b. Kind of Business/Industry <b>Landscaping</b>				
17. Father's Name (First, Middle, Last) <b>Clyde Harrison Asbury</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Oveland Rogers</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Elizabeth R. Asbury - Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>20882</b> <b>24344 Flamingo Terrace, Gaithersburg, Maryland</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Parklawn Memorial Park</b>		20c. Location - City or Town, State <b>12/28/98 Rockville, Maryland</b>				
21. Signature of Funeral Service Licensee <b>Olin L. Molesworth</b>				22. Name and Address of Facility <b>Olin L. Molesworth P.A., Funeral Home</b> <b>26401 Ridge Road, Damascus, Maryland 20872</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Coronary Artery Disease</b> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>12/22/98</b>		28b. Time of Injury <b>0845</b> M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred <b>Subject shot self</b>		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>AT HOME</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>24344 Flamingo Terrace</b>				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <b>John Locke</b>				29c. License number <b>O.C.M.E</b>		29d. Date signed (Month, Day, Year) <b>DEC. 23, 1998</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>John Locke, MD 111 Penn Street, Baltimore, Maryland 21201</b>								
31. Date filed (Month, Day, Year) <b>DEC 28 1998</b>				32. Registrar's Signature <b>B. Sparks</b>				

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41467

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) BARBARA ARTHINE BAKER				2. Date of Death Month Day Year DECEMBER 23, 1998		3. Time of Death 6:00 A.M.			
	4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick			
Funeral Director	5. Social Security Number 224-72-3947		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 68 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) June 28, 1930		9. Birthplace (State or Foreign Country) West Virginia	
	Usual Residence of Decedent									
10a. State Maryland		10b. County Frederick		10c. City, Town or Location Thurmont				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 1 Sandy Spring Court					10f. Zip Code 21788		10g. Citizen of What Country? U.S. of A.			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Caucasian		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+)					16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry own home		
17. Father's Name (First, Middle, Last) Carl Lake					18. Mother's Name (First, Middle, Maiden Surname) Mabel Taylor Green					
19a. Informant's Name/Relationship (Type, Print) Rebekah J. Stansberry - Daughter					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 56 W. Frederick St., Walkersville, Md. 21793					
20e. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory			Date 12-24-98		20c. Location - City or Town, State Alexandria, Virginia		
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility Brown Funeral Home Lovettsville, Virginia					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Cardiomyopathy</u> Due to (or as a consequence of): Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Approximate Interval Between Onset and Death <u>2 months</u>										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
							24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
							24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier 					29c. License number D36649		29d. Date signed (Month, Day, Year) 12/23/98			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Edward Riuli, M.D. 310 W. 9th. Street Frederick, Maryland										
31. Date filed (Month, Day, Year) DEC 28 1998			32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at 800-555-0055.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



BRYAN K. BITTNER

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 41468

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) BRYAN KEITH BITTNER				2. Date of Death Month Day Year DEC. 21, 1998		3. Time of Death 1214 PM	
	4a. Facility Name (If not institution, give street and number) WASHINGTON COUNTY HOSPITAL				4b. City, Town, or Location of Death HAGERSTOWN		4c. County of Death WASHINGTON	
Funeral Director	5. Social Security Number 215-78-3130		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 38 Yrs.		8. Date of Birth (Month, Day, Year) July 16, 1960	
	9. Birthplace (State or Foreign Country) Illinois		10a. State Maryland		10b. County Frederick		10c. City, Town or Location Sabillasville	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 17517 Harbaugh Valley Rd.		10f. Zip Code 21780		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 1		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Carpenter		16b. Kind of Business/Industry Academy			
	17. Father's Name (First, Middle, Last) Robert E. Bittner, Jr.				18. Mother's Name (First, Middle, Maiden Surname) Betty L. Saylor			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Pamela Toms Bittner (Wife)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17517 Harbaugh Valley Rd., Sabillasville, MD 21780			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Smithsburg Crematory		20c. Location - City or Town, State 12/23/98 Smithsburg, Maryland			
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Robert E. Dailey & Son Funeral Homes, P.A. 615 East Main St., Thurmont, MD 21788			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Coronary Arteriosclerotic Disease</u> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
					24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 			
	29c. License number O.C.M.E				29d. Date signed (Month, Day, Year) DEC. 22, 1998			
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201							
	31. Date filed (Month, Day, Year) DEC 30 1998				32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 41469

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

June Hope Butler

2. Date of Death

Month Day Year  
December 25, 1998

3. Time of Death

7:15 A.M.

4a. Facility Name (If not institution, give street and number)

6855 Buttonwood Court

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

Funeral  
Director

5. Social Security Number

214-03-8276

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
May 6, 1916

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6855 Buttonwood Court

10f. Zip Code

21703

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Rozell

BROWN

18. Mother's Name (First, Middle, Maiden Surname)

Valvie

Hope

WAGNER

19a. Informant's Name/Relationship (Type, Print)

Lynn H. Suter, Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

593 Primus Court, Frederick, MD 21703

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Smithsburg Crematory, Dec. 28, 1998

Date

20c. Location - City or Town, State

Smithsburg, Maryland

21. Signature of Funeral Service Licensee

▶ Allan H. Ruby MO0703

22. Name and Address of Facility

Keeney &amp; Basford P.A. Funeral Home

106 East Church street, Frederick, MD 21701

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. EXTENSIVE MYOCARDIAL INFARCTION

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

6 m

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

▶ [Signature] M.D.

29c. License number

P1462C

29d. Date signed (Month, Day, Year)

Dec 25, 1998

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

P. Gregory Rausch, M.D., 501 West Seventh Street, Frederick, MD 21701

31. Date filed (Month, Day, Year)

DEC 28 1998

32. Registrar's Signature

▶ [Signature] B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 41470

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Jerome Brown				2. Date of Death Month Day Year December 26, 1998				3. Time of Death 3:45 P.M.			
	4a. Facility Name (If not institution, give street and number) FREDERICK MEMORIAL HOSPITAL				4b. City, Town, or Location of Death FREDERICK				4c. County of Death FREDERICK			
Funeral Director	5. Social Security Number 218-30-7844		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 62 Yrs.		8. Date of Birth (Month, Day, Year) FEB. 21, 1936		9. Birthplace (State or Foreign Country) MD			
	Usual Residence of Decedent											
To Be Completed by Funeral Director	10a. State MD.		10b. County FREDERICK		10c. City, Town or Location FREDERICK				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	10e. Street and Number 3561 HOPELAND RD.				10f. Zip Code 21704		10g. Citizen of What Country? U.S.A.					
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: BLACK				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 TH Collegia (1-4or 5+)				18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CEMENT FINISHER			16b. Kind of Business/Industry CONSTRUCTION/MASONARY <del>CONSRT</del>				
	17. Father's Name (First, Middle, Last) LLOYD DANIEL BROWN				18. Mother's Name (First, Middle, Maiden Surname) MARIE LEE							
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) MILDRED BROWN				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3561 HOPELAND RD. FREDERICK, MD. 2170							
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) HOPEHILL CEM.		Data DEC. 31, 1998		20c. Location - City or Town, State FRED. MD.			
	21. Signature of Funeral Service Licensee Gary L. Rollins				22. Name and Address of Facility GARY L. ROLLINS FUNERAL HOME 110 WEST SOUTH ST. FRED, MD. 21701							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hemorrhage. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>respiratory failure</u> Due to (or as a consequence of): b. <u>extensive lung cancer</u> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 1 hr 12 mo											
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No											
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
					28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
	29b. Signature and title of certifier [Signature]				29c. License number 014622				29d. Date signed (Month, Day, Year) DEC 26, 1998			
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D G Trausch MD 501 W 7th St Frederick MD 21701											
	31. Date filed (Month, Day, Year) DEC 29 1998				32. Registrar's Signature [Signature]							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



98-7491-001

CLIFFORD BITTINGER

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

B.K.S

ITEMS: #23 PART I, 27, 28A-F PER MEO G769 3-3-99

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Clifford Ray Bittinger</b>				2. Date of Death Month Day Year <b>DEC. 19, 1998</b>		3. Time of Death <b>5:16 PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>MEMORIAL HOSPITAL</b>				4b. City, Town, or Location of Death <b>CUMBERLAND</b>		4c. County of Death <b>ALLEGANY</b>		
Funeral Director	5. Social Security Number <b>218-74-5434</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>37</b> Yrs.	8. Under 1 Year Months Days	9. Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>May 2, 1961</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State <b>MD</b>	10b. County <b>Garrett</b>	10c. City, Town or Location <b>Swanton</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	10e. Street and Number <b>573 New Germany Road</b>			10f. Zip Code <b>21561</b>		10g. Citizen of What Country? <b>USA</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9th</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Bottler</b>			16b. Kind of Business/Industry <b>Cumberland Water Sales</b>			
	17. Father's Name (First, Middle, Last) <b>Forrest William Bittinger</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Edna Marie Otto</b>				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Forrest W. Bittinger/Father</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>197 Water Wheel Road, Oakland, Md. 21550</b>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Bittinger Family Cem.</b>		Date <b>12/23</b>		20c. Location - City or Town, State <b>Swanton, Md.</b>		
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Stewart Funeral Home 32 S. Second St., Oakland, Md. 21550</b>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>GUNSHOT OF CHEST</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>a. Due to (or as a consequence of):</b> <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>								
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input type="checkbox"/> Natural <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>2-19-98</b>		28b. Time of Injury <b>2:10</b> p <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>SUBJECT WAS SHOT when muzzleloader went off when vehicle struck a fixed object.</b>	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>O.C.M.E</b>		29d. Date signed (Month, Day, Year) <b>DEC. 21, 1998</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MDrymonas P. Korou 111 Penn Street, Baltimore, Maryland 21201</b>									
State Registrar	31. Date filed (Month, Day, Year) <b>DEC 24 1998</b>		32. Registrar's Signature 						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 41472

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mondell Lavernia Brown

2. Date of Death

12

Day

25

Year

3. Time of Death

11:50am

4a. Facility Name (If not institution, give street and number)

Cuppett &amp; Weeks Nursing Home

4b. City, Town, or Location of Death

Oakland

4c. County of Death

Garrett

Funeral  
Director

5. Social Security Number

235-80-1222

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

7/27/1917

9. Birthplace (State or Foreign Country)

WV

Usual Residence of Decedent

10a. State

MD

10b. County

Garrett

10c. City, Town or Location

Oakland

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

706 E. Adler Street

10f. Zip Code

21550

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
if Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8th

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Domestic

17. Father's Name (First, Middle, Last)

Lonnie Shahan

18. Mother's Name (First, Middle, Maiden Surname)

Arizona Bolyard

19a. Informant's Name/Relationship (Type, Print)

Mildred O'Haver/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

411 Shenandoah Avenue, Mt. Lake Park, MD 21550

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Pine Run Cemetery

Date

12/28/98

20c. Location - City or Town, State

Terra Alta, WV

21. Signature of Funeral Service Licensee

Lionel Smith - Treasurer

22. Name and Address of Facility

Arthur H. Wright Funeral Home  
105 Highland Avenue  
Terra Alta, WV 2676423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e. Pneumonia

Due to (or as a consequence of):

b. COPD - Chronic obstructive pulmonary disease 10 yrs

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

2 wks

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Alzheimers

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural5 ☐ Pending Investigation2 ☐ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

DR. SAVOPOULOS

29c. License number

17374

29d. Date signed (Month, Day, Year)

12-28-98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. SAVOPOULOS Rt 1 Box 5 A1 TERRA ALTA WV 26764

31. Date filed (Month, Day, Year)

DEC 30 1998

32. Registrar's Signature

Beverly B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 41473

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>James Lee Cummings</b>				2. Date of Death Month <b>December</b> Day <b>21</b> Year <b>1998</b>		3. Time of Death <b>2:31 AM</b>		
	4a. Facility Name (If not Institution, give street and number) <b>Frederick Memorial Hospital</b>				4b. City, Town, or Location of Death <b>Frederick</b>		4c. County of Death <b>Frederick</b>		
Funeral Director	5. Social Security Number <b>217 09 1914</b>		6. Sex <b>1</b> M <b>2</b> F		7. Age (In yrs. last birthday) <b>93</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>2/25/05</b>		
	9. Birthplace (State or Foreign Country) <b>MD</b>		10a. State <b>MD</b>		10b. County <b>Frederick</b>		10c. City, Town or Location <b>Brunswick</b>		
Usual Residence of Decedent		10d. Inside City Limits <b>X</b> Yes <b>2</b> No		10e. Street and Number <b>106 East "A" Street</b>		10f. Zip Code <b>21716</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <b>1</b> Never Married <b>2</b> Married <b>3</b> Widowed <b>4</b> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <b>1</b> Yes <b>2</b> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> Yes <b>2</b> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Trainman</b>		16b. Kind of Business/Industry <b>B&amp;O Railroad</b>					
17. Father's Name (First, Middle, Last) <b>James Lee Cummings, Sr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Nettie Violet Evans</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Mary E. Cummings</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>106 East "A" Street, Brunswick, MD 21716</b>					
20a. Method of Disposition <b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State <b>4</b> Donation <b>5</b> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Old Brethren Cemetery</b>		Date <b>12/23</b>		20c. Location - City or Town, State <b>Brownsville, MD</b>			
21. Signature of Informant <b>Banbara A. Williams, Owner</b>		22. Name and Address of Facility <b>John T. Williams Funeral Home</b>		100 Petersville Rd Brunswick MD 21716					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Myocardial Infarction</b>		Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.		Approximate Interval Between Onset and Death <b>15 mks</b>					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Right chest Blunt Trauma</b>						23b. Did tobacco use contribute to the cause of death? <b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown			
24a. Was an autopsy performed? <b>1</b> Yes <b>2</b> No		24b. Were autopsy findings available prior to completion of cause of death? <b>1</b> Yes <b>2</b> No							
25. Was case referred to medical examiner? <b>1</b> Yes <b>2</b> No		26. Place of Death (Check only one) Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify)							
27. Manner of Death <b>1</b> Natural <b>5</b> Pending investigation <b>2</b> Accident <b>6</b> Could not be determined <b>3</b> Suicide <b>4</b> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <b>1</b> Yes <b>2</b> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <b>X</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Max Wilger DMD</b>		29c. License number <b>D20281</b>		29d. Date signed (Month, Day, Year) <b>12/21/98</b>			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Max Wilger DMD, 74 Thomas Johnson Dr., Frederick, MD</b>		31. Date filed (Month, Day, Year) <b>DEC 28 1998</b>		32. Registrar's Signature <b>Geneva B. Sparks</b>					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 41474

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Robert Lee CLISER</b>				2. Date of Death Month Day Year <b>December 25, 1998</b>		3. Time of Death <b>5:15 A.M.</b>		
	4a. Facility Name (If not institution, give street and number) <b>Frederick Memorial Hospital</b>				4b. City, Town, or Location of Death <b>Frederick</b>		4c. County of Death <b>Frederick</b>		
Funeral Director	5. Social Security Number <b>233-66-6994</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>57</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>April 16, 1941</b>	9. Birthplace (State or Foreign Country) <b>West Virginia</b>	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>Frederick</b>		10c. City, Town or Location <b>Frederick</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <b>408 Columbus Avenue</b>				10f. Zip Code <b>21701</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
	11. Marital Status <input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1959 to 1965</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5+</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Business Manager</b>		18b. Kind of Business/Industry <b>State Government</b>				
	17. Father's Name (First, Middle, Last) <b>Robert Martin Cliser</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Alice Mae Dawson</b>				
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Mary Helen Cliser/wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>408 Columbus Ave., Frederick, MD 21701</b>				
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Smithsburg Crematory Dec.</b>		Date <b>30, 1998</b>		20c. Location - City or Town, State <b>Smithsburg, Maryland</b>		
	21. Signature of Funeral Service Licensee <i>Robert C. Cliser</i>		22. Name and Address of Facility <b>Keeney and Basford Funeral Home 106 East Church Street, Frederick, MD 21701</b>						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Cancer of the Lung</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>								
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Philip Shapiro</i>		29c. License number <b>007186</b>		29d. Date signed (Month, Day, Year) <b>12/28/98</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Philip Shapiro, M.D., 814 Toll House Ave., Frederick, MD 21701</b>									
31. Date filed (Month, Day, Year) <b>DEC 28 1998</b>		32. Registrar's Signature <i>Geneva S. Smith</i>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41475

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>James Arthur CUTSAIL, JR.</b>				2. Date of Death Month <b>December</b> Day <b>25</b> Year <b>1998</b>		3. Time of Death <b>12:25 P.m.</b>	
	4a. Facility Name (If not institution, give street and number) <b>Citizens Nursing Home of Frederick Co.</b>				4b. City, Town, or Location of Death <b>Frederick</b>		4c. County of Death <b>Frederick</b>	
Funeral Director	5. Social Security Number <b>215-26-8267</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>90</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>April 16, 1908</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>Frederick</b>		10c. City, Town or Location <b>Frederick</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>1080 Rocky Springs Road</b>		10f. Zip Code <b>21702</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Farmer</b>		16b. Kind of Business/Industry <b>Farming</b>			
	17. Father's Name (First, Middle, Last) <b>James A. Cutsail, Sr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Grace A. Baker</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Ruth E. Cutsail/Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1080 Rocky Springs Road, Frederick, MD 21701</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Frederick Memorial Park</b>		20c. Date <b>Dec. 29, 1998</b>		20d. Location - City or Town, State <b>Frederick, MD</b>	
	21. Signature of Funeral Service Licensee <i>Richard C. L. Basford</i> 100021		22. Name and Address of Facility <b>Keeney &amp; Basford Funeral Home</b> <b>106 East Church Street, Frederick, MD 21701</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Respiratory failure.</b> Due to (or as a consequence of): <b>b. COPD.</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>2 mos</b> <b>10 yrs</b>							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
			28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of Certifier <i>Robert L. Kaufmann</i>		29c. License number <b>D13971</b>		29d. Date signed (Month, Day, Year) <b>12/28/98</b>			
State Registrar	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Robert L Kaufmann 300 W. 9th St. Frederick, MD 21701</b>							
	31. Date filed (Month, Day, Year) <b>DEC 28 1998</b>		32. Registrar's Signature <i>B. Spence</i>					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



98-7632-023

BOYD LEE COOPER

ASP

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

ITEMS: #23 PART 1, 27, 28A-F PER MEO

G767-20-99 WR 98 41476

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>BOYD LEE COOPER</b>				2. Date of Death Month Day Year <b>DECEMBER 28 1998</b>		3. Time of Death <b>1534 P</b>									
	4a. Facility Name (If not institution, give street and number) <b>GARRETT MEMORIAL HOSPITAL</b>				4b. City, Town, or Location of Death <b>OAKLAND</b>		4c. County of Death <b>GARRETT</b>									
Funeral Director	5. Social Security Number <b>233-70-0055</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>57</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>OCT 1, 1941</b>		9. Birthplace (State or Foreign Country) <b>MARYLAND</b>								
	Usual Residence of Decedent															
10a. State <b>MD</b>		10b. County <b>GARRETT</b>		10c. City, Town or Location <b>OAKLAND</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
10e. Street and Number <b>3851 CRANESVILLE ROAD</b>				10f. Zip Code <b>21550</b>		10g. Citizen of What Country? <b>USA</b>										
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>										
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>BUS BOY</b>		16b. Kind of Business/Industry <b>RESTAURANT</b>										
17. Father's Name (First, Middle, Last) <b>SYLVANAS B. COOPER</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>MAE VIOLA PARKS</b>												
19a. Informant's Name/Relationship (Type, Print) <b>THEODORE TRUBAN - BROTHER</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>12400 BLADES RD. CORDOVA, MD 21625</b>												
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>FAIRVIEW CEMETERY</b>		Date <b>12/31/98</b>		20c. Location - City or Town, State <b>OAKLAND, MARYLAND</b>										
21. Signature of Funeral Service Licensee  <b>MO0167</b>				22. Name and Address of Facility <b>P.O. BOX 243 DURST FUNERAL HOME - OAKLAND, MD 21550</b>												
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																
<table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a.</td> <td><b>MULTIPLE INJURIES</b> Due to (or as a consequence of):</td> </tr> <tr> <td>b.</td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>c.</td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> <td>Due to (or as a consequence of):</td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	<b>MULTIPLE INJURIES</b> Due to (or as a consequence of):	b.	Due to (or as a consequence of):	c.	Due to (or as a consequence of):	d.	Due to (or as a consequence of):
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	<b>MULTIPLE INJURIES</b> Due to (or as a consequence of):														
	b.	Due to (or as a consequence of):														
	c.	Due to (or as a consequence of):														
	d.	Due to (or as a consequence of):														
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown										
						24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)														
27. Manner of Death <input type="checkbox"/> Natural <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>12-27-98</b>		28b. Time of Injury <b>5:15</b> P M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
		28d. Describe how injury occurred <b>DRIVER OF CAR RAN OFF ROAD</b>		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>ROAD</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>CRANESVILLE ROAD, GARRETT COUNTY, MD.</b>										
29e. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																
29b. Signature and title of certifier 				29c. License number <b>O.C.M.E</b>		29d. Date signed (Month, Day, Year) <b>DECEMBER 29, 1998</b>										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MARGARET M. GRILLE 111 Penn Street, Baltimore, Maryland 21201</b>																
31. Date filed (Month, Day, Year) <b>DEC 30 1998</b>		32. Registrar's Signature 														

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

6

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

30 41477

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>KENNETH LEE DAY</b>				2. Date of Death Month Day Year <b>DECEMBER 25, 1998</b>		3. Time of Death <b>11:58 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>Frederick Memorial Hospital</b>				4b. City, Town, or Location of Death <b>Frederick</b>		4c. County of Death <b>Frederick</b>		
Funeral Director	5. Social Security Number <b>514-32-2590</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>68</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>June 26, 1930</b>		
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10. Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County <b>Frederick</b> 10c. City, Town or Location <b>Ijamsville</b> 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: <b>Korea</b>		
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Storekeeper Foreman</b>		16b. Kind of Business/Industry <b>U.S. Government</b>	
17. Father's Name (First, Middle, Last) <b>Murray D. Day</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Lois E. Burdette</b>				19. Informant's Name/Relationship (Type, Print) <b>Rowena Day - Wife</b>	
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Bethesda Methodist Cemetery 12/29/98</b>				20c. Location - City or Town, State <b>Damascus, Maryland</b>	
21. Signature of Funeral Service Licensee <i>Olin L. Molesworth</i>				22. Name and Address of Facility <b>Olin L. Molesworth P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872-0117</b>				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  a. <i>End stage renal failure</i> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):	
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined	
28a. Date of Injury (Month, Day, Year)				28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>Ali J. Afrookteh MD</i>				29c. License number <b>D35183</b>	
29d. Date signed (Month, Day, Year) <b>12/26/98</b>				30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Ali J. Afrookteh 300 W 9th St, Frederick, MD</b>				31. Date filed (Month, Day, Year) <b>DEC 10 1998</b>	
32. Registrar's Signature <i>Benita B. Jones</i>									

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Physician  
/Medical  
Examiner

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item# 10b per FH G767 1/19/99 EW  
Item: 1 per M.D G-767 1/14/99 reb

## Certificate of Death

Reg. No.

98 41478

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>BERNARD Preston DUFF</b>				2. Date of Death Month <b>DECEMBER</b> Day <b>26</b> Year <b>1998</b>		3. Time of Death <b>0623</b>	
	4a. Facility Name (If not institution, give street and number) <b>CONTINUUM CARE AT SYKESVILLE</b>				4b. City, Town, or Location of Death <b>SYKESVILLE</b>		4c. County of Death <b>CARROLL</b>	
Funeral Director	5. Social Security Number <b>705-12-4979</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (in yrs. last birthday) <b>88</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>11/14/1910</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent							
10a. State <b>Md.</b>		10b. County <b>Carroll</b>		10c. City, Town or Location <b>Mount Airy</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>17360 Frederick Road</b>				10f. Zip Code <b>21771</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4or 5+) <b>0</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Carpenter</b>		16b. Kind of Business/Industry <b>Construction</b>		
17. Father's Name (First, Middle, Last) <b>Wayman Duff</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Sadie E. Hickey</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Clyde Boone/Personal Rep.</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7322 Woodbine Road Woodbine, Maryland 21797</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>St. John's Cemetery</b>		20c. Location - City or Town, State <b>12/29/98 Ellicott City, Md.</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Jeffrey N. Zubrun Funeral Home 6028 Sykesville Road Eldersburg, Maryland 21784</b>				
23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>CONGESTIVE HEART FAILURE</b>								Approximate Interval Between Onset and Death
Due to (or as a consequence of):								
Due to (or as a consequence of):								
Due to (or as a consequence of):								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>COPD</b>								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
				28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number <b>D37333</b>		29d. Date signed (Month, Day, Year) <b>DECEMBER 26, 1998</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>C. RAVI MD NHC, BALTO, MD 21133</b>								
31. Date filed (Month, Day, Year) <b>DEC 28 1998</b>				32. Registrar's Signature 				

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



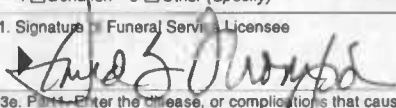
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 41479

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Marion Earl</b>				2. Date of Death Month <b>Dec.</b> Day <b>16,</b> Year <b>1998</b>		3. Time of Death <b>10:15 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>Montgomery Village Healthcare and Rehab</b>				4b. City, Town, or Location of Death <b>Gaithersburg</b>		4c. County of Death <b>Montgomery</b>		
Funeral Director	5. Social Security Number <b>199-32-7533</b>		8. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>84</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>May 3, 1914</b>	9. Birthplace (State or Foreign Country) <b>New York</b>	
	Usual Residence of Decedent								
10a. State <b>Md.</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Gaithersburg</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>19301 Watkins Mill Rd.</b>				10f. Zip Code		10g. Citizen of What Country? <b>U.S.A.</b>			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>2</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>registered nurse</b>		18b. Kind of Business/Industry <b>medical</b>			
17. Father's Name (First, Middle, Last) <b>Charles Vosburgh</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Anna Leutz</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Paul Earl (Son)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>12109 Mericks Ct., Monrovia, Md. 21770</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Jeffries Farm Cemetery</b>		Date <b>12/18</b>		20c. Location - City or Town, State <b>Petersburg, Pa.</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Donald B. Thompson Funeral Home 31 E. Main St., Middletown, Md. 21769</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. LEUKEMIA</b> Due to (or as a consequence of): <b>b. ANEMIA</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>								Approximate Interval Between Onset and Death <b>MONTHS</b> <b>MONTHS</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>D30692</b>		29d. Date signed (Month, Day, Year) <b>DECEMBER 21, 1998</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. GABRIEL BERNABE 15200 SHADY GROVE RD ROCKVILLE MD. 20850</b>									
31. Date filed (Month, Day, Year) <b>DEC 23 1998</b>		32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

BARBARA ANN FRYE

2. Date of Death  
Month Day Year  
December 21, 19983. Time of Death  
16.15

4a. Facility Name (If not institution, give street and number)

800 Motter Avenue

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

5. Social Security Number

218-34-3702

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

61 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Oct. 12, 1937

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

800 Motter Avenue

10f. Zip Code

21701

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Grayson Martin Miss

18. Mother's Name (First, Middle, Maiden Surname)

Mary Lee Johnson

19a. Informant's Name/Relationship (Type, Print)

Mary A. Miss (Sister-in-law)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

350 East 3rd Street, Frederick, Maryland 21701

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Smithsburg Crematory

Date

12/8/98

20c. Location - City or Town, State

Smithsburg, Maryland

21. Signature of funeral service provider

22. Name and Address of Facility

ROBERT E. DAILEY & SON FUNERAL HOMES, P.A.  
1201 NORTH MARKET ST., FREDERICK, MD 21701

23a. Pertinent Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or brain failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

MYOCARDIAL INFARCTION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

CORONARY ART DISEASE

Due to (or as a consequence of):

ATHEROSCLEROSIS

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

COPD

ASTHMA

Schizophrenia - Osteoarthritis

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No26. Place of Death (Check only one)  
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 8 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Naaz Hussain M.D.

29c. License number

D46861

29d. Date signed (Month, Day, Year)

12/23/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Naaz Hussain, MD 195 Thomas Johnson Drive, Frederick, Maryland 21701

State  
Registrar

31. Date filed (Month, Day, Year)

DEC 23 1998

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) EDNA MAE FRIEDMAN					2. Date of Death Month Day Year December 14, 1998		3. Time of Death 12:30pm	
	4a. Facility Name (If not institution, give street and number) 16 West Main Street, Apt.#3					4b. City, Town, or Location of Death Thurmont		4c. County of Death Frederick	
Funeral Director	5. Social Security Number 131-36-0589		6. Sex 1 <input type="checkbox"/> M 3 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs. 74	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Dec. 6, 1924		9. Birthplace (State or Foreign Country) England
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State Maryland		10b. County Frederick		10c. City, Town or Location Thurmont			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number 16 West Main St., Apt.#3				10f. Zip Code 21788		10g. Citizen of What Country? U.S.A.		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home			
	17. Father's Name (First, Middle, Last) Thomas James Latimer					18. Mother's Name (First, Middle, Maiden Surname) Gertrude Maude Fowler			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) TERRY SHOOK (NEPHEW)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 110 TACOMA ST. THURMONT, MD 21788				
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Smithsburg Crematory		Date 12/17/98		20c. Location - City or Town, State Smithsburg, Maryland		
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Robert E. Dailey & Son Funeral Homes, P.A. 615 East Main St., Thurmont, MD 21788				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Atherosclerotic Cardiovascular Disease</u> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 10 years
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Hypertension</u>								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
	29b. Signature and title of certifier 				29c. License number D0035152		29d. Date signed (Month, Day, Year) December 16, 1998		
State Registrar	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) J. Lee Krantz, M.D., 100 S. Center St., Thurmont, MD 21788								
	31. Date filed (Month, Day, Year) DEC 23 1998				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41482

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Annie May Fincham</b>				2. Date of Death Month <b>December</b> Day <b>24</b> Year <b>1998</b>		3. Time of Death <b>12:30 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>College View Nursing Center</b>				4b. City, Town, or Location of Death <b>Frederick</b>		4c. County of Death <b>Frederick</b>	
Funeral Director	5. Social Security Number <b>226-26-0023</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>89</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Aug. 23, 1909</b>	
	9. Birthplace (State or Foreign Country) <b>Virginia</b>		10e. State <b>Maryland</b>		10b. County <b>Frederick</b>		10c. City, Town or Location <b>Monrovia</b>	
To Be Completed by Funeral Director	Usual Residence of Decedent				10f. Zip Code <b>21770</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	17. Father's Name (First, Middle, Last) <b>William Richards</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Blanche Weakley</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Florence V. Fellers - Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>11637 Fingerboard Road, Monrovia, Maryland 21770</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Washington Cemetery</b>		20c. Location - City or Town, State <b>12/29/98 Washington, Virginia</b>	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Olin L. Molesworth P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872-0117</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Cerebrovascular Accident</b> Due to (or as a consequence of):  <b>b. Dementia</b> Due to (or as a consequence of):  <b>c. Sternal Decubitus Ulcer</b> Due to (or as a consequence of):  <b>d.</b>				Approximate Interval Between Onset and Death <b>Days</b>  <b>Years</b>  <b>3 Months</b>			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 				
29c. License number <b>D43091</b>				29d. Date signed (Month, Day, Year) <b>7-28-98</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Saeed A. Zaidi, M.D. 801 Toll House Avenue, Frederick, Maryland 21701</b>				31. Date filed (Month, Day, Year) <b>DEC 30 1998</b>				
32. Registrar's Signature 								



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41483

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ELOISA NETTIE GIFFT				2. Date of Death Month Day Year DEC. 26, 1998		3. Time of Death 8:30am		
	4a. Facility Name (If not Institution, give street and number) 423 NORTH CHURCH ST.				4b. City, Town, or Location of Death THURMONT		4c. County of Death FREDERICK		
Funeral Director	5. Social Security Number 214-10-3916		8. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 82 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) JAN. 16, 1916		
	9. Birthplace (State or Foreign Country) MARYLAND								
To Be Completed by Funeral Director	Usual Residence of Decedent								
	10a. State MARYLAND		10b. County FREDERICK		10c. City, Town or Location THURMONT			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number 423 NORTH CHURCH ST.				10f. Zip Code 21788		10g. Citizen of What Country? U.S.A.		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER			18b. Kind of Business/Industry OWN HOME			
	17. Father's Name (First, Middle, Last) CHARLES HENRY HARRISON STITELY				18. Mother's Name (First, Middle, Maiden Surname) ESTHER FLORENCE CARTY				
	19a. Informant's Name/Relationship (Type, Print) CAROLYN K. SHARER (DAUGHTER)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 423 NORTH CHURCH ST., THURMONT, MD 21788				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) RESTHAVEN MEMORIAL GARDENS			Date 12/29/98		20c. Location - City or Town, State FREDERICK, MARYLAND	
	21. Signature of Funeral Service Licensee				22. Name and Address of Facility ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 615 EAST MAIN ST., THURMONT, MD 21788				
	Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Renal failure Due to (or as a consequence of): b. Type II Diabetes Due to (or as a consequence of): c. Hypertension Due to (or as a consequence of): d.							
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown									
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No									
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Coronary Artery Disease Anemia								
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)						
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	28d. Describe how injury occurred				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
State Registrar	29b. Signature and title of certifier Bonita J. Portier, D.O.				29c. License number H44037		29d. Date signed (Month, Day, Year) DECEMBER 28, 1998		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bonita J. Portier, D.O. 310 S. SETON AVE., EMMITSBURG, MD 21727								
	31. Date filed (Month, Day, Year) DEC 30 1998				32. Registrar's Signature Bonita J. Portier				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





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State of Maryland / Department of Health and Mental Hygiene 98 41484

Certificate of Death

Reg. No.

1. Decedent's Name (First, Middle, Last) <b>Evelyn O. Hurley</b>		2. Date of Death Month <b>December</b> Day <b>20</b> , Year <b>1998</b>		3. Time of Death <b>7:10PM</b>	
4a. Facility Name (If not institution, give street and number) <b>13047 Penn Shop Road</b>		4b. City, Town, or Location of Death <b>Mount Airy</b>		4c. County of Death <b>Frederick</b>	
5. Social Security Number <b>214-74-6589</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>89</b> Yrs.	
8. Date of Birth (Month, Day, Year) <b>Sept. 30, 1909</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>			
Usual Residence of Decedent		10a. State <b>Maryland</b>		10b. County <b>Frederick</b>	
10c. City, Town or Location <b>Mt. Airy</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number <b>13047 Penn Shop Road</b>		10f. Zip Code <b>21771</b>		10g. Citizen of What Country? <b>United States</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Nurse</b>	
16b. Kind of Business/Industry <b>Nursing</b>		17. Father's Name (First, Middle, Last) <b>Woodward O'Hara</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Hattie Scarff</b>	
19a. Informant's Name/Relationship (Type, Print) <b>Gail Bastian/ Daughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>13047 Penn Shop Road, Mt. Airy, Maryland 21771</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Montgomery Methodist Cemetery</b>		20c. Location - City or Town, State <b>12/23 Damascus, Maryland</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Olin L. Molesworth P. A. Funeral Home</b> <b>26401 Ridge Road, Damascus, Maryland 20872</b>			
23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. colon carcinoma (had resection 9/15/58)</b> Due to (or as a consequence of): <b>b. adenomatous polyps of colon</b> Due to (or as a consequence of): <b>c. adult onset diabetes</b> Due to (or as a consequence of): <b>d. history of coronary artery disease</b>		Approximate Interval Between Onset and Death <b>~3 1/2 months</b> <b>&gt;10 yrs</b> <b>&gt;10 yrs</b> <b>&gt;10 yrs</b>			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>glaucoma, Hypertension, cardiac arrhythmies including atrial fibrillation, chronic constipation, Hypertrophic cardiomegaly, allergic rhinitis</b>					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>D34682</b>	
29d. Date signed (Month, Day, Year) <b>December 21, 1998</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Joanne L. Kinney, M.D. 9701 New Church Street, Damascus, Maryland 20872</b>					
31. Date filed (Month, Day, Year) <b>DEC 23 1998</b>		32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar



PHILLIP  
HOFF

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State of Maryland / Department of Health and Mental Hygiene

98 41485

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Phillip Nelson Hoff						2. Date of Death Month Day Year DECEMBER 20, 1998		3. Time of Death 10:30A.M.		
	4a. Facility Name (If not institution, give street and number) 6114-B MOUNT PHILLIP ROAD						4b. City, Town, or Location of Death FREDERICK		4c. County of Death FREDERICK		
Funeral Director	5. Social Security Number 217-56-1047		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 48 Yrs.		8. Date of Birth (Month, Day, Year) April 21, 1950		9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent										
10a. State Maryland		10b. County Frederick		10c. City, Town or Location Frederick				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number 5756 Sunset View Lane				10f. Zip Code 21703		10g. Citizen of What Country? U.S.A.					
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 1				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Animal Control Officer				16b. Kind of Business/Industry County Government			
17. Father's Name (First, Middle, Last) Donald Phillip Hoff						18. Mother's Name (First, Middle, Maiden Surname) G. Lucille MURPHY					
19a. Informant's Name/Relationship (Type, Print) Mary R. Hoff, Wife						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5756 Sunset View Lane, Frederick, MD 21703					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Smithsburg Crematory, Dec. 22, 1998		20c. Location - City or Town, State Smithsburg, Maryland					
21. Signature of Funeral Service Licensee Alan H. Ruby MO0703				22. Name and Address of Facility Keeney & Basford P.A. Funeral Home 106 East Church Street, Frederick, MD 21701							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. Intra-oral shotgun wound Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
								24a. Was an autopsy performed? Limited <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) WOODS							
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year) Found 12-20-98		28b. Time of Injury unknown M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) woods		28d. Describe how injury occurred subject shot self					
				28f. Location (Street and Number or Rural Route Number, City or Town, State) 6114-B Mt. Phillip Frederick County, Maryland							
29e. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier Attysh A. Macleary						29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) DECEMBER 21, 1998			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201											
31. Date filed (Month, Day, Year) DEC 22 1998				32. Registrar's Signature B. Spahr							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Anna Margaret Holder</b>				2. Date of Death Month <b>Dec.</b> Day <b>16,</b> Year <b>1998</b>		3. Time of Death <b>1:45 PM</b>														
	4a. Facility Name (If not institution, give street and number) <b>Frederick Memorial Hospital</b>				4b. City, Town, or Location of Death <b>Frederick</b>		4c. County of Death <b>Frederick</b>														
Funeral Director	5. Social Security Number <b>220-28-3227</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>82</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Feb. 12, 1916</b>														
	10a. State <b>Md.</b>		10b. County <b>Frederick</b>		10c. City, Town or Location <b>Middletown</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No														
To Be Completed by Funeral Director	10e. Street and Number <b>14 Locust Blvd.</b>				10f. Zip Code <b>21769</b>		10g. Citizen of What Country? <b>U.S.A.</b>														
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>														
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7</b> College (1-4or 5+)				16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>cashier</b>		16b. Kind of Business/Industry <b>pharmacy</b>														
	17. Father's Name (First, Middle, Last) <b>Charles Stanley Minnick</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Irene Elizabeth Baker</b>																
	19a. Informant's Name/Relationship (Type, Print) <b>Woodrow N. Holder (Husband)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>14 Locust Blvd., Middletown, Md. 21769</b>																
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematorium or other place) <b>Brownsville Hgts. Cemetery</b>		Date <b>12/20</b>		20c. Location - City or Town, State <b>Brownsville, Md.</b>														
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Donald B. Thompson Funeral Home 31 E. Main St., Middletown, Md. 21769</b>																
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																				
	<table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a.</td> <td><b>MYOCARDIAL INFARCTION</b></td> <td>Hours</td> </tr> <tr> <td>b.</td> <td><b>HYPERTENSION</b></td> <td>YEARS</td> </tr> <tr> <td>c.</td> <td><b>HYPERTENSION</b></td> <td>YEARS</td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	<b>MYOCARDIAL INFARCTION</b>	Hours	b.	<b>HYPERTENSION</b>	YEARS	c.	<b>HYPERTENSION</b>	YEARS	d.		
	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	<b>MYOCARDIAL INFARCTION</b>	Hours																	
b.		<b>HYPERTENSION</b>	YEARS																		
c.		<b>HYPERTENSION</b>	YEARS																		
d.																					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>END STAGE RENAL DISEASE</b> <b>HYPERKALEMIA</b>						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown															
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No																			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No															
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred																			
28f. Location (Street and Number or Rural Route Number, City or Town, State)																					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																					
29b. Signature and title of certifier  <b>MN</b>				29c. License number <b>D 47556</b>		29d. Date signed (Month, Day, Year) <b>12/23/98</b>															
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>187 THOMAS J. JOHNSON DRIVE FREDERICK MD 21702 WILLIAM H. JOHNSON</b>																					
31. Date filed (Month, Day, Year) <b>DEC 23 1998</b>		32. Registrar's Signature 																			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. "nature", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 41487

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) BARBARA ANN HOLLAND				2. Date of Death Month Day Year DECEMBER 27, 1998		3. Time of Death 10:45 AM	
	4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick	
Funeral Director	5. Social Security Number 212-50-9886		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 49 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) March 16, 1949	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
10a. State Maryland		10b. County Frederick		10c. City, Town or Location Frederick			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10e. Street and Number 700 Toll House Avenue				10f. Zip Code 21701		10g. Citizen of What Country? U.S.A.		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) 10				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home		
17. Father's Name (First, Middle, Last) Robert Mervin ELLIS				18. Mother's Name (First, Middle, Maiden Surname) Maude Mary SMITH				
19a. Informant's Name/Relationship (Type, Print) Mrs. Maude Mary Ellis, Mother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 808 East South Street, Frederick, MD 21701				
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Smithsburg Crematory, Dec. 29, 1998		Data Date		20c. Location - City or Town, State Smithsburg, Maryland	
21. Signature of Funeral Service Licensee Richard E. Huff MO0255				22. Name and Address of Facility Keeney and Basford P.A. Funeral Home 106 East Church St., Frederick, MD 21701				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Myocardial infarction Due to (or as a consequence of): b. coronary artery disease Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death months
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. urinary tract infections gastroenteritis stroke						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Jed Hylton		29c. License number D 22161		29d. Date signed (Month, Day, Year) 12/19/98		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lloyd Halvorson, MD, 1475 Taney Ave., Frederick, Maryland 21702								
31. Date filed (Month, Day, Year) DEC 30 1998				32. Registrar's Signature B. Sparks				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Mary Olive Hering

2. Date of Death

December 26, 1998

3. Time of Death

5:00 P.M.

4a. Facility Name (If not Institution, give street and number)

Frederick Memorial Hospital

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

5. Social Security Number

218-24-1299

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

June 22, 1921

9. Birthplace (State or Foreign Country)

Indiana

Usual Residence of Decedent

10a. State

MD

10b. County

Frederick

10c. City, Town or Location

Knoxville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3658 Petersville Road

10f. Zip Code

21758

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Homemaker

17. Father's Name (First, Middle, Last)

Glenn Tingle Swisher

18. Mother's Name (First, Middle, Maiden Surname)

Bessie Catherine Scott

19a. Informant's Name/Relationship (Type, Print)

Robert T. Hering, Sr. Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P. O. Box 310 - Fairfield, PA 17320

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Hagenstown Crematory 12/28/98 Hagenstown, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Barbara A. Williams, Owner

22. Name and Address of Facility

John T. Williams Funeral Home  
Brunswick, MD 2171623a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e. Pulmonary fibrosis

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

years

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Mycobacterium avium

Due to (or as a consequence of):

months

c. gastric Reflux

Due to (or as a consequence of):

year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dialysis machine

adrenal insufficiency

hypothyroidism

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ NoHospital: 1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending  
2 ☐ Accident 6 ☐ Could not be  
3 ☐ Suicide 6 ☐ investigation  
4 ☐ Homicide 6 ☐ determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

John T. Williams

29c. License number

D22101

29d. Date signed (Month, Day, Year)

12/28/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Helen H. Williams 1475 Lang Ave, Frederick Md 21701

31. Date filed (Month, Day, Year)

DEC 28 1998

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 41489

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) CALVIN Matthew JAMES		2. Date of Death Month Day Year December 15, 1998		3. Time of Death 1:40 PM	
4a. Facility Name (If not institution, give street and number) College View Health Center			4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick
5. Social Security Number 214-34-1170		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 60 Yrs.		8. Date of Birth (Month, Day, Year) Feb. 13, 1938
9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Frederick	
10c. City, Town or Location Frederick		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
10e. Street and Number All Saints St.		10f. Zip Code 21701		10g. Citizen of What Country? United States	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) 10		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer	
16b. Kind of Business/Industry Manufacturing		17. Father's Name (First, Middle, Last) Lewis Clavin James		18. Mother's Name (First, Middle, Maiden Surname) Martha Riggs	
19a. Informant's Name/Relationship (Type, Print) Justine Anderson / sister		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9545 Keys Chapel Rd. / Union Bridge, Md. 21791			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Resthaven Memorial Cem.		20c. Location - City or Town, State 12-19-98 Frederick, Maryland	
21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike / Frederick, Md. 21702			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Cerebral Infarction</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death 2 weeks			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Diabetes Mellitus</i>				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
				24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>William H. Conway, MD</i>		29c. License number D20395	
		29d. Date signed (Month, Day, Year) 12/15/98			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>195 Thomas Lawrence Drive, Frederick, Md 21702</i>					
31. Date filed (Month, Day, Year) DEC 21 1998		32. Registrar's Signature <i>B. Spark</i>			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 4 14 90

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Beverly Jane JONES				2. Date of Death Month Day Year December 28, 1998		3. Time of Death 11:55 pm	
	4a. Facility Name (If not institution, give street and number) Northampton Manor Nursing Center				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick	
Funeral Director	5. Social Security Number 216-14-6971		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 74 Yrs.		8. Date of Birth (Month, Day, Year) May 27, 1924	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Frederick		10c. City, Town or Location Frederick	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 1709 West Seventh Street		10f. Zip Code 21702		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 8		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home			
	17. Father's Name (First, Middle, Last) George William Albert FOX				18. Mother's Name (First, Middle, Maiden Surname) Gladys Credella HARRISON			
	19a. Informant's Name/Relationship (Type, Print) Mrs. Betty E. Blentlinger/Sister				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9428 Gas House Pike, Frederick, Maryland 21701			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt Olivet Cemetery Dec 31, 1998		20c. Location - City or Town, State Frederick, Maryland			
	21. Signature of Funeral Service Licensee <i>[Signature]</i> MO0706		22. Name and Address of Facility Keeney & Basford P.A. Funeral Home 106 East Church St, Frederick, Maryland 21701					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Ischemic Cardiomyopathy Due to (or as a consequence of): b. Diabetes Mellitus Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Moderate Renal Insufficiency C.V.A., Dementia, Hypertension						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>[Signature]</i> MD		29c. License number D21944		29d. Date signed (Month, Day, Year) December 29, 1998		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James S. Grissom, M.D., 300 West Ninth Street, Frederick, Maryland 21701								
31. Date filed (Month, Day, Year) DEC 30 1998		32. Registrar's Signature <i>[Signature]</i>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

Reg. No.

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>Gladys Virginia Joslin</b>					2. Date of Death Month <b>Dec</b> Day <b>29</b> Year <b>1998</b>		3. Time of Death <b>11:25 am</b>		
	4a. Facility Name (If not institution, give street and number) <b>Cuppett-Weeks Nursing Home</b>				4b. City, Town, or Location of Death <b>Oakland</b>		4c. County of Death <b>Garrett</b>			
<b>Funeral Director</b>	5. Social Security Number <b>219-46-2014</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>83</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Apr 29 1915</b>		9. Birthplace (State or Foreign Country) <b>Pa.</b>	
	Usual Residence of Decedent									
10a. State <b>Md</b>		10b. County <b>Garrett</b>		10c. City, Town or Location <b>Oakland</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>706 East Alder St</b>					10f. Zip Code <b>21550</b>		10g. Citizen of What Country? <b>USA</b>			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>2</b>					18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Housewife</b>			16b. Kind of Business/Industry <b>Homemaker</b>		
17. Father's Name (First, Middle, Last) <b>John Wilson</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Minnie Paugh</b>					
19a. Informant's Name/Relationship (Type, Print) <b>LeRoy J. Friend</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>403 Lake Ave. Terra Alta, WVa 26764</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>IOOF Cemetery</b>			20c. Location - City or Town, State <b>Dec 31 98 Elk Garden W.Va</b>				
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility <b>David A. Burdock Funeral Home 710 Church St. Kitzmiller Md 21538</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> </div> <div style="width: 60%;"> <p>a. <b>Pneumonia 2-3 days</b> Due to (or as a consequence of):</p> <p>b. _____ Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____ Due to (or as a consequence of):</p> </div> </div>										Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.  <div style="display: flex; justify-content: space-between;"> <div style="width: 65%;"> <p><b>ASHD</b></p> <p><b>Seizure disorder</b></p> </div> <div style="width: 30%;"> <p>23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown</p> <p>24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> </div> </div>										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA      Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> <b>Certifying Physician:</b> To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> <b>Medical Examiner:</b> On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier 					29c. License number <b>D0015333</b>		29d. Date signed (Month, Day, Year) <b>12/29/98</b>			
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) <b>Thomas J. Johnson, M.D., 311 North Fourth Street, Oakland, MD 21550</b>										
31. Date filed (Month, Day, Year) <b>DEC 30 1998</b>					32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,







Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) <b>Frederick George Kelly</b>				2. Date of Death Month <b>December</b> Day <b>26</b> Year <b>1998</b>		3. Time of Death <b>6:16 P.M.</b>	
4a. Facility Name (If not institution, give street and number) <b>Frederick Memorial Hospital</b>				4b. City, Town, or Location of Death <b>Frederick</b>		4c. County of Death <b>Frederick</b>	
5. Social Security Number <b>072-14-1101</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>76</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>March 29, 1922</b>	9. Birthplace (State or Foreign Country) <b>New York</b>
Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Frederick</b>		10c. City, Town or Location <b>Frederick</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>2463 Five Shillings Road</b>				10f. Zip Code <b>21701</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5+</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Social Worker</b>		16b. Kind of Business/Industry <b>Federal Government</b>	
17. Father's Name (First, Middle, Last) <b>Roberty KELLY</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Marie MCCLUSKY</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Mrs. Audrey J. Kelly, wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2463 Five Shillings Rd., Frederick, MD 21701</b>			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Smithsburg Crematory, December 30, 1998</b>		Date <b>December 30, 1998</b>		20c. Location - City or Town, State <b>Smithsburg, Maryland</b>	
21. Signature of Funeral Service Licensee <b>Richard E. Shay</b> <b>MO0255</b>				22. Name and Address of Facility <b>Keeney and Basford P.A. Funeral Home</b> <b>106 East Church St., Frederick, MD 21701</b>			
23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
Immediate Cause (Final disease or condition resulting in death) a. <b>Atherosclerotic Cardiovascular Disease</b> <b>Year</b> Due to (or as a consequence of):							
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of):							
c. Due to (or as a consequence of):							
d. Due to (or as a consequence of):							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Non Hodgkins Lymphoma</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how Injury occurred			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier <b>Dr. J. L. Krantz M.D.</b>				29c. License number <b>D0035152</b>		29d. Date signed (Month, Day, Year) <b>12-28-98</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>J. L. Krantz, M.D. 180 Thos. Johnson Drive, Frederick MD</b>							
31. Date filed (Month, Day, Year) <b>DEC 30 1998</b>				32. Registrar's Signature <b>P. Sparks</b>			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



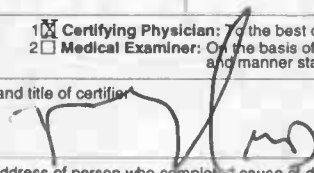


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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Mamie Irene LOWERY</b>				2. Date of Death Month <b>December</b> Day <b>24</b> , Year <b>1998</b>				3. Time of Death <b>8:15 AM</b>		
	4a. Facility Name (If not Institution, give street and number) <b>Northampton Manor Nursing Home</b>				4b. City, Town, or Location of Death <b>Frederick</b>				4c. County of Death <b>Frederick</b>		
Funeral Director	5. Social Security Number <b>214-82-5576</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>92</b> Yrs.		8. Date of Birth Month <b>Nov.</b> Day <b>8</b> , Year <b>1906</b>		9. Birthplace (State or Foreign Country) <b>Virginia</b>		
	Usual Residence of Decedent										
10a. State <b>Maryland</b>		10b. County <b>Frederick</b>		10c. City, Town or Location <b>Frederick</b>				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
10a. Street and Number <b>200 East 16th Street</b>				10f. Zip Code <b>21701</b>				10g. Citizen of What Country? <b>U.S.A.</b>			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4or 5+) <b>Homemaker</b>				18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>				16b. Kind of Business/Industry <b>Own Home</b>			
17. Father's Name (First, Middle, Last) <b>Giles R. Corell</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Addie A. Feather</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Joyce K. Horton, Granddaughter</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7780 Sharwood Drive, Jessup, MD 20794</b>					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Ft. Lincoln Cemetery</b>		Date <b>Dec. 28, 1998</b>		20c. Location - City or Town, State <b>Brentwood, MD</b>			
21. Signature of Funeral Service Licensee  M00021				22. Name and Address of Facility <b>Keeney and Basford P.A. Funeral Home</b> <b>106 East Church St., Frederick, MD 21701</b>							
23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Acute Renal Failure</b> e. Due to (or as a consequence of):  Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.										Approximate Interval Between Onset and Death <b>1 Week</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Obstructive Jaundice</b> <b>Dementia</b> <b>Coagulopathy</b>								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred	
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 				29c. License number <b>D 32171</b>		29d. Date signed (Month, Day, Year) <b>December 24, 1998</b>	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Richard Gough MD 19 West Frederick Street, P.O. Box 328, Walkersville, MD 21793</b>											
31. Date filed (Month, Day, Year) <b>DEC 28 1998</b>				32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JEAN ELIZABETH FERGUSON LADINO						2. Date of Death Month Day Year DECEMBER 22, 1998		3. Time of Death 10:50 AM	
	4a. Facility Name (If not institution, give street and number) 8207 Edgewood Church Road						4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick	
Funeral Director	5. Social Security Number 212-50-7916		8. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 78 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Location Maryland Frederick Frederick		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 8207 Edgewood Church Road		10f. Zip Code 21702		10g. Citizen of What Country? United States	
To Be Completed by Funeral Director		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white		
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 Collega (1-4or 5+) -		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry self				
17. Father's Name (First, Middle, Last) Dr. John Ferguson						18. Mother's Name (First, Middle, Maiden Surname) Olive Bennion				
19a. Informant's Name/Relationship (Type, Print) Tess Davis / daughter						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8211 Edgewood Church Road, Frederick, MD 21702				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)						20b. Place of Disposition (Name of cemetery, crematory or other place) Resthaven Mem Gardens		20c. Location - City or Town, State 12/26/98 Frederick, Maryland		
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, MD 21702				
23a. Part I. Enter the disease, or complications that caused death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) End Stage Ischemic Heart Disease Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):						Approximate Interval Between Onset and Death 6 months				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 8 <input type="checkbox"/> Could not be determined						28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		
						28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
						28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						29b. Signature and title of certifier 		29c. License number D21944		
						29d. Date signed (Month, Day, Year) 12/22/98				
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Jones S. Grissom MD 300 W 9th St. Frederick, Md 21701										
31. Date filed (Month, Day, Year) DEC 23 1998						32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23e-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98 41496

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) OSCAR CLINTON LINTON JR.				2. Date of Death Month Day Year DECEMBER 18, 1998		3. Time of Death 7:45AM
	4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick
Funeral Director	5. Social Security Number 220-18-1731	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 72 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Feb 27, 1926	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent						
To Be Completed by Funeral Director	10a. State Maryland	10b. County Frederick	10c. City, Town or Location Frederick			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 9426 Bethel Road			10f. Zip Code 21702		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Truck Driver		16b. Kind of Business/Industry County Highway Dept		
	17. Father's Name (First, Middle, Last) Oscar Clinton LINTON Sr				18. Mother's Name (First, Middle, Maiden Surname) Edna Rebecca NUSZ		
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Mrs. June E. Keilhiltz Linton/Wife, 9426 Bethel Road, Frederick, Maryland 21702				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Faith U.C.C. Cemetery Dec 21, 1998		20c. Location - City or Town, State Charlesville, MD		
	21. Signature of Funeral Service Licensee Keeney & Basford P.A. Funeral Home 106 East Church St, Frederick, Maryland 21701				22. Name and Address of Facility		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Severe End stage COPD Due to (or as a consequence of): Bibasilar Pneumonia Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Approximate Interval Between Onset and Death 5 yrs. 4 days						
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Peripheral Vascular Disease I.T.P. - post splenectomy Osteoporosis Hx C.A.D.						
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	28d. Describe how Injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier James S. Grisson M.D.		
	29c. License number D21944				29d. Date signed (Month, Day, Year) 12/18/98		
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James S. Grisson M.D., 300 W 9th St., Frederick, Md, 21701						
	31. Date filed (Month, Day, Year) DEC 21 1998		32. Registrar's Signature B. Spahr				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last)

Theodore E. Lewis

2. Date of Death  
Month Day Year

December 17 1998

3. Time of Death

2250

4a. Facility Name (If not Institution, give street and number)

Shady Grove Adventist Hospital

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

5. Social Security Number

018-20-0166

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

72

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

March 31 1926

9. Birthplace (State or Foreign Country)

NY

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Laytonsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9607 Harvest Knolls Way

10f. Zip Code

20882

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever In U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: 44-46

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

18e. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Sales

16b. Kind of Business/Industry

Insurance

17. Father's Name (First, Middle, Last)

Samuel I. Goldberg

18. Mother's Name (First, Middle, Maiden Surname)

Sadye Galitzka

19e. Informant's Name/Relationship (Type, Print)

Bradford Lewis/son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9607 Harvest Knolls Way, Laytonsville, MD 20882

20e. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Enders/Shirley F.H.

Date

12/20

20c. Location - City or Town, State

Berryville, Va.

21. Signature of Funeral Service Licensee

*[Signature]*

22. Name and Address of Facility

Hilton Funeral Home

Box 86 Barnesville, Md.

20838

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Chronic obstructive pulmonary disease

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury  
(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

*[Signature]* MD

29c. License number

29453

29d. Date signed (Month, Day, Year)

December 18, 1998

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

ALAN S. CHANALIS 15245 SHADY GROVE RD ROCKVILLE MD 20850

31. Date filed (Month, Day, Year)

DEC 22 1998

32. Registrar's Signature

*[Signature]*

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

17

*Handwritten signature or mark*



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State of Maryland / Department of Health and Mental Hygiene 98 41498

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Donald L. Lowe, Sr.

2. Date of Death  
Month Day Year

December 29, 1998

3. Time of Death

3:43 AM

4a. Facility Name (If not institution, give street and number)

Shady Grove Adventist Hospital

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

5. Social Security Number

212-24-4550

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

70

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

Jan. 24, 1928

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Damascus

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

24524 Ridge Road

10f. Zip Code

20872

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: WWII13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
6

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Contractor

16b. Kind of Business/Industry

Heating &  
Air Conditioning

17. Father's Name (First, Middle, Last)

Ernest Lowe

18. Mother's Name (First, Middle, Maiden Surname)

Lillian Earp

19a. Informant's Name/Relationship (Type, Print)

Donald L. Lowe, Jr. - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

90 Waverly Drive - F101 Frederick, Maryland 21702

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Forest Oak Cemetery

Date

12/31/98 Gaithersburg, Maryland

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Robert L. Williams

22. Name and Address of Facility

Olin L. Molesworth P.A., Funeral Home  
26401 Ridge Road, Damascus, Maryland 20872-0111

23a. Pertinent to the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final  
disease or condition  
resulting in death)

a. VENTRICULAR ARRHYTHMIA

Due to (or as a consequence of):

b. LARGE CELL, INTERMEDIATE GRADE LYMPHOMA

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

1/2 HOUR

8 MONTHS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ATRIAL FIBRILLATION

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation  
6 ☐ Could not be determined28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Chitra Rajagopal M.D.

29c. License number

MARYLAND D42452

29d. Date signed (Month, Day, Year)

29<sup>th</sup> DAY OF DECEMBER  
1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. CHITRA RAJAGOPAL, M.D.  
18111, PRINCE PHILIP DRIVE, SUITE 327, OLNEY, MD 20832

31. Date filed (Month, Day, Year)

DEC 30 1998

32. Registrar's Signature

James B. Spaulding

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner







Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 41500

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

William Edwin Love

2. Date of Death  
Month Day Year  
December 29 19983. Time of Death  
1800

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

Funeral  
Director

5. Social Security Number

218-30-1811

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

63

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

June 3, 1935

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State

Maryland

10b. County

Caroline

10c. City, Town or Location

Denton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7295 Dion Road

10f. Zip Code

21629

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No -  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.Specify:  
Caucasian15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12 HS Grad.

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Farmer

16b. Kind of Business/Industry

Farming

17. Father's Name (First, Middle, Last)

Frederick Earl Love

18. Mother's Name (First, Middle, Maiden Surname)

Florence Elizabeth Seeders

19a. Informant's Name/Relationship (Type, Print)

Betty L. Love Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7295 Dion Road, Denton, Maryland 21629

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Concord Cemetery

Date

1/2/99

20c. Location - City or Town, State

near Denton, Maryland

21. Signature of Funeral Service Licensee

Charles V. Moore

22. Name and Address of Facility

Moore Funeral Home, P.A.

12 South Second Street, Denton, Maryland 21629

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Pneumonia

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cerebral vascular accident  
Metastatic prostate cancer

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24e. Was an autopsy  
performed?1 ☐ Yes 2 ☐ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined28e. Date of Injury  
(Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J. A. Cockroy, MD

29c. License number

025674

29d. Date signed (Month, Day, Year)

12/20/98

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

J. A. Cockroy, MD 100 Power St, Salisbury, MD 21804

31. Date filed (Month, Day, Year)

JAN - 5 1999

32. Registrar's Signature

P. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

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